00:00:04.160 --> 00:00:06.100 Y eah.

00:00:10.460 --> 00:00:33.240 Alright hello, we can get started. We have a forum and everybody’s already still quiet so I come to the first grand rounds of the year. It’s my pleasure to introduce the speakers today, so right now. Lim will be our first speaker. She’s assistant professor of ophthalmology and visual science and she’s a director of the smilow cancer hospitals ocular oncology program.

00:00:33.780 --> 00:01:02.900 She received her MD from the State University of New York Downstate Medical School and also trained under Carol Shields and will die. Husband Philadelphia, Philadelphia and she completed 2 fellowships when an ocular plastic surgery and in ocular oncology and she is the director of the archaeology program and sees patients was common and rare malignancies of the eyes and will speak to us today about ophthalmic immune related adverse events, so by contacting him.

00:01:07.620 --> 00:01:26.650 Thank you so much for the kind introduction, my name is Ronald Lemon. Today I’ll talk to you about the ophthalmic immune related adverse events and share our experience, I have no financial disclosures, although a few of my coauthors are consultants.

00:01:27.170 --> 00:01:57.720 Target recognition by T cells is a 2 step process. The mechanism of action of checkpoint inhibitors and detail a few cases. We can all agree that the relationship between the immune system and cancer is complex with the realization that cancer finds ways to escape detection by the immune system.

00:01:58.480 --> 00:02:13.820 Target recognition by T cells is a 2 step process. The 1st is an interaction between the T cell receptor and that MHC complex or major histocompatibility complex displayed by tumor cells or antigen presenting cells.
The 2nd event is a Co regulatory signal that determines whether the T cell becomes activated or down regulated and the 2nd event will be illustrated here.

You can think of CTLA for a receptor on the surface of activated T cells as one of the brakes of the immune system because it functions to down regulate the T cells to help prevent autoimmunity and inflammation.

When the interaction of B7 and CTLA4 takes place it’s like stepping on the brakes inhibiting the TSLT cells also expressed another receptor called CD28, which is Constitutively expressed and serves an opposing function to CTLA4.

Triggering T cell activation when CD28 binds to B7. It’s like stepping on the gas pedal and the T cell remains active to go kill cancer.

CTLA4 competes with CD28 for B7 binding, but CTLA4 has a much higher affinity to kill cancer cells. The cytotoxic T cell should remain active so how do we keep the T cell active?

By preventing the binding of CTLA4, NB7 altogether in 2011, the FDA approved it belimo map a monoclonal antibody for treatment of advanced metastatic cutaneous Melanoma. It’s been 9 years since approval of it be limam anti. PD one and P. DL1 way later approved by the FDA based on successful. Large, randomized, controlled clinical trials now immunotherapy is considered one of the pillars of cancer therapy.

Prior to the introduction of immunotherapy the 10 year survival rate for metastatic Melanoma was less than 10%.

Survival rates for Advanced Stage 3 or 4 unresectable metastatic cutaneous Melanoma are even better when combination therapy is employed. The five year data was recently published demonstrating that the overall survival of advanced metastatic Melanoma was 52% in the combination group of Nuvola. Mab and if you limo. Mab there are currently 7 FDA approved immune checkpoint inhibitors.
And the indication for use of immune checkpoint inhibitors are continually growing to not only involve unresectable advanced metastatic cutaneous Melanoma, but squamous cell carcinoma of the head and neck. Merkel cell carcinoma of paddle cellular carcinoma renal cell carcinoma cervical cancer and the list continues.

We recently published our experience with immunotherapy and the atomic immune related adverse events because the use of immunotherapy continues to grow the adverse events will expand and it’s important to be mindful that there are ophthalmic immune related adverse events.

We reviewed the charts of almost 1500 patients and 15 of them or 1% developed in al thalmic immune related adverse event. Most patients were treated with combination therapy. It belima map and Nuvola Mab, the most common ophthalmic immune related adverse event was uveitis.

Interesting Lee all patients who had ophthalmic immune related adverse events also had concomitant systemic immune related adverse events such as colitis dermatitis arthritis. Hepatitis Hypophysitis and the list goes on.

Now let’s discuss a few unique cases.

This is a 75 year old man with a history of left foot Melanoma, who developed widespread metastasis. He was treated with two cycles of hippie anevo and complained of seeing distorted images anterior segment examination showed an irregular pupil.

This patient was managed with Topical Corticosteroids Topical Prednisone. And you can see a little bit of scarring and this is what we call posterior synechiae where the iris is adherent to the anterior lens capsule. This patient was managed with Topical Corticosteroids Topical Prednisone.

And after one month you see release of the posterior sneaky and he now has around pupil.
So I mentioned that uveitis was the most common ophthalmic immune related adverse event and I’d like to take a minute to just talk about what uveitis is: it simply inflammation of the UV A and the uvea consists of the iris, the ciliary body, and the choroid.

Uveitis can manifest in many different ways. Patients can present with debris on the back of the corneal endothelium and we call this keratic precipitates.

Our patients can have cells in the anterior chamber. Usually, it should be white and quiet. But when cells are present, we know there’s some underlying inflammation.

Or have posterior synechiae and that’s anterior uveitis, but UV I just cannot affect the back of the eye. More and we call that posterior the ritis or core roditis and you can see inflammation affecting the choroid and sometimes the retinal vascular cherr.

Here’s another case: a 57-year-old woman with a history of choroidal melanoma and you see a pigmented lesion affecting the choroid. She was treated with black breakey therapy and you see very nice regression of the pigmented lesion, however. Later, she developed liver metastasis. She was treated with hippie, Lumaban nuvola mab, and receive just one cycle. She then developed a rash in 2 weeks later, she presented with left upper eyelid ptosis and diplopia. A work up was performed and she had elevated CK levels.

Myositis elevated proponents myocarditis, and she had acetylcholine. Receptor antibodies and she was diagnosed with myasthenia gravis, myositis, and myocarditis. She was hospitalised and treated with intravenous corticosteroids, immunoglobulins empire, it’ll stick mean and she had complete resolution of her ophthalmic symptoms at 6 months. However, she did have progression of disease in later received radio embolization for worsening liver metastasis.

This is a case report and I thought this was interesting because it’s very similar to our patient and the authors described in a 80 year old man with a history of cutaneous melanoma metastatic to lymph nodes.
who developed fatigue shortness of breath, weakness After 2 weeks 2 weeks after starting nuvola. Mab the authors obtained baseline acetylcholine. Receptor antibody level in this patient had low levels of acetylcholine receptor antibodies.

NOTE Confidence: 0.901727259159088

00:09:42.050 --> 00:09:49.440 However, after treatment with nuvola mab, we can see a spike in the acetylcholine receptor antibodies in it.

NOTE Confidence: 0.911805033683777

00:09:51.210 --> 00:10:01.070 And after immunoglobulin you see the acetylcholine receptor antibody level decrease in the same was true for the CK levels.

NOTE Confidence: 0.923823058605194

00:10:02.230 --> 00:10:34.720 The patient had a skeletal muscle biopsy T cell receptor analysis using next generation sequencing identified infiltration of Clonally expanded T cell populations in skeletal muscle after treatment with nuvola mab and these high numbers of T cells found in the skeletal muscle biopsy suggest a strong T cell immune response against muscular skeletal, muscular cells. Here’s another case a 43 year old woman with a history of metastatic cutaneous Melanoma.

NOTE Confidence: 0.848947167396545

00:10:34.720 --> 00:10:37.470 Received 3 cycles of it being evil.

NOTE Confidence: 0.924616575241089

00:10:38.190 --> 00:10:40.030 She complained of blurry vision.

NOTE Confidence: 0.923079252243042

00:10:40.540 --> 00:11:02.200 Fundoscopic examination showed choroiditis and you can see the areas of inflammation affecting the core ride. She was treated with systemic corticosteroids with improvement in her visual acuity and she achieved 2020 vision in both eyes. An she had a complete response to treatment and is now followed every six months.

NOTE Confidence: 0.910990357398987

00:11:03.790 --> 00:11:32.040 Here’s another case a 54 year old women with a history of Angel Melanoma with brain metastasis who is treated with combination therapy who also complained blurry vision, Visual Acuity was 2070. In both eyes in the photos at the Top. This is called optical coherence tomography and this is our version of a see T scan of the eye and it essentially scans. The retinal layers and you can see fluid deep to the retina.

NOTE Confidence: 0.923568367958069

00:11:33.980 --> 00:11:44.670 This patient was treated with systemic corticosteroids with improvement in her visual acuity to 2025 in both eyes. However, she had progression of her metastatic disease and is now deceased.
This is another interesting case of a 61 year old woman with a history of metastatic cutaneous Melanoma who complained of blurry vision, especially of the left eye. Funduscopic examination showed bilateral disk edema you can see swelling of the optic nerves visual field testing showed severe constriction.

Everything that you see outlined in black is an area of her visual field that she could not see so this patient was treated with systemic corticosteroids. However, there was no improvement in her best corrected visual. Acuity immunotherapy was stopped because the patient also had low ritis and floral Fusion, she had progression of disease, Ann is now deceased.

This is another case of a 54 year old man with a history of metastatic cutaneous Melanoma who received one cycle of combination therapy and complained of progressive visual loss.

Here you can see pockets of subretinal fluid and you see yellow material. It’s forming a little bit of a meniscus. We call this patelliform material. So you see 1 central large pocket of fluid an multiple satellite pockets of fluid.

This patient was diagnosed with acute oxidative polymorphous the Teleform Maculopathy, an the subretinal fluid was confirmed an optical coherence tomography.

This is a report of a patient very similar to the one I just described but the patient developed acute exit dative polymorphism. Patelliform maculopathy after me. Rafa nib and pembrolizumab with similar clinical features, however, not as dramatic as our patient.

A 79 year old women with metastatic cutaneous Melanoma complained of Photopsia. We’re seeing flashes of light just after one cycle of a belimo mab and Nuvola Mab.

Her funduscopic examination was completely normal there was no deviation from baseline. No evidence of chorditis know sub-
retinal fluid. No evidence of uveitis so she went on to receive another cycle of combination therapy. Then she developed transamnitis.

NOTE Confidence: 0.888502717018127

00:14:11.610 --> 00:14:22.320 Hypophysitis and Dermatitis as well as worsening of her ophthalmic symptoms, worsening photopsia and she had difficulty seeing at night nyctalopia.

NOTE Confidence: 0.894903242588043

00:14:23.970 --> 00:14:40.220 Because of her trans amanita sin hypopituitarism. She was treated with intravenous solu medrol with without resolution of her ophthalmic symptoms. At this point Melanoma associated retinopathy was high on the differential.

NOTE Confidence: 0.909739911556244

00:14:40.770 --> 00:15:03.080 So, an electroretinogram was performed and if you look to the left, you can see what a normal. I will look like the B wave has that very high amplitude indicated by the arrow. But in our patients right and left eye. She had a severely attenuated be wave.

NOTE Confidence: 0.906665027141571

00:15:05.390 --> 00:15:13.440 Anti retinal antibodies were also obtained an were positive in our patient and she was diagnosed with Melanoma associated retinopathy.

NOTE Confidence: 0.877081751823425

00:15:14.340 --> 00:15:25.130 So how do we treat these conditions if mild and if uveitis is just anterior we can treat these patients with topical Prednisolone?

NOTE Confidence: 0.894618332386017

00:15:25.740 --> 00:15:59.430 In more advanced cases, we can administer steroids via injection. Perry ocular injections or intravitreal injections. An tored the right. You can see a Depot. The white material is kenna log and there’s a Depot in his superior, temporal fornix here. Sometimes patients are managed with Prednisone others. Other times patients have to undergo treatment with corticosteroids or immunoglobulins an rarely do we use plasma pheresis?

NOTE Confidence: 0.924751102924347

00:16:02.470 --> 00:16:11.980 In summary immune checkpoint inhibitors are powerful agents, which allow cytotoxic T cells to remain active in attack cancer cells.
The atomic immune related adverse events are real. The incidents is about 1% and can occur within weeks to months of therapy and can affect various parts of the eye and orbit. Patient can have dry eye conjunctivitis keratitis uveitis serious retinal detachment optic neuritis. An myositis so when these patients have dry eye. These can be managed with topical lubrication. Patients can present with conjunctivitis where you see redness of the conjunctiva and these are mild symptoms and can be managed with eyedrops. However, keratitis can be more visually debilitating in cause blurry vision. We actually had a patient who had a corneal perforation. Where the cornea actually opened and the intraocular contents can then be extruded if the keratitis is severe? UVritis we talked about posterior sneaky a we talked about anterior chamber cell. Serious retinal detachment wear there's fluid underneath the retina. We talked about optic neuritis or optic disc edema and loss severe loss of visual field function.
Autoimmune Retinopathy again, these patients can have a normal I exam normal fundoscopic findings.

NOTE Confidence: 0.868023157119751

ERG or electroretinogram will show an attenuated be wave, which signifies loss of bipolar cells.

NOTE Confidence: 0.899324834346771

And we discussed Cora Dietis, where I remember the core right is part of the UV and so this is a type of posterior uveitis. Our patients who had a uveal Melanoma developed my senior gravis after just one cycle of combination therapy and she presented with left upper eyelid ptosis and double vision.

NOTE Confidence: 0.89207895704651

And here’s an example of what myositis looks like of the extraocular muscles. You see the medial rectus enlarged in axial in Corona views.

NOTE Confidence: 0.861285388469696

Impatience can present with cranial nerve palsies as well.

NOTE Confidence: 0.937500178813934

Thank you.

NOTE Confidence: 0.806050300598145

Any questions with temple questions.

NOTE Confidence: 0.555100381374359

So I have.

NOTE Confidence: 0.396336793899536

Notice.

NOTE Confidence: 0.67575991153717

How often do you?

NOTE Confidence: 0.775518774986267

The perspective in comparison to the junior right? That’s a great question the question was.

NOTE Confidence: 0.932260632514954

How does the use of immune checkpoint inhibitors differ for uveal Melanoma when compared to cutaneous Melanoma?
Unfortunately, when uveal Melanoma metastasizes there is no great treatment. So we employ the use of immune checkpoint inhibitors. However, about 10 to 15% of patients will respond does not have a great overall survival that cutaneous Melanoma has.

An in that patient, she actually still had progression of disease, she only received one cycle of combination therapy. But she had to undergo radio embolization.

I've a question so do you see a correlation between the types of symptoms. You see in the eyes and their systemic side effects on in our study. We did not see that now. Some people hypothesize that if patients develop immune related adverse events that these patients are more likely to respond to immunotherapy and more likely to have an improvement in overall survival. But when looking at the ophthalmic immune related adverse event there was no correlation.

As just wondering about the etiology of the optic neuritis. You don’t biopsy anything there. So you’re just seeing the papilledema or the disc edema right so do you know what’s going on? Is it art easels infiltrating the optic nerve is an antibody mediated or nobody knows or not you know it’s immune related I think that’s what I meant.

Well, in that we have to put the whole picture together in this setting of using immune checkpoint inhibitors in again. These patients when they present with a thaumic immune related adverse events. They also have other types of inflammation in the rest of the body so.

Yeah, we can assume that this is all related to immunotherapy, but no one is.
Do you have any additional questions in the middle? I'm not sure I need to make it there?

Hello.

And.

So the question was how long does it take between the diagnosis of Melanoma an the actual symptoms. So what we looked at was not necessarily the time of diagnosis of Melanoma, but more when immune checkpoint inhibitors were started and from the time when the immune checkpoint inhibitors are started to the time of ophthalmic immune related adverse events.

It varies from weeks to several months.

More questions.

No OK. Thank you very much.