

# Exercise Treatment as Part of Multidisciplinary Whole Person Care in Oncology

Several national agencies, including the American Society of Clinical Oncology (ASCO), recommend the prescription of exercise for patients diagnosed with cancer.<sup>1,2</sup> The evidence base for these recommendations is derived from studies that showed exercise-related improvements in patient-reported outcomes (PROs), treatment-associated adverse effects, cardiorespiratory fitness (CRF), and overall physical functioning.<sup>3-6</sup> Additionally, exercise may have direct anticancer effects and indirect effects by synergizing standard cancer therapies.<sup>7,8</sup> Despite these benefits, the implementation of exercise oncology practice guidelines in the United States has been limited. A major barrier to the implementation of exercise therapy and other “whole person interventions” is the increasing complexity of clinical decision-making due to the greater availability of novel cancer therapeutics with clinical benefits ranging from low to high impact.

The associated decision-making paradigm requires highly nuanced conversations, planning, and more time for discussion between patients and their oncologists to develop an efficacious treatment approach that aligns with patient priorities while balancing potential toxicity. Within this context, the consideration of any additional treatment recommendation, such as exercise, is scrutinized against competing priorities to maximize clinical efficiency. Questions regarding the optimal use of exercise (eg, when to implement, type, and dosage of exercise) have made it challenging to prescribe exercise as part of a cancer treatment plan, relegating exercise to the realm of “general recommendations” that are mentioned but often forgotten.

Fortunately, guidelines from ASCO and the American College of Sports Medicine now



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include important details for exercise therapy implementation such as established safety and dosing information.<sup>2</sup> Several randomized control trials have demonstrated that exercise after completion of cancer therapy improves various PROs and CRF.<sup>3,4</sup> Additional studies have demonstrated that supervised exercise during chemotherapy is safe and tolerable.<sup>9</sup> Supervised exercise during chemotherapy also has early efficacy for mitigating chemotherapy-related decline in CRF.<sup>10</sup> Patients who initiate exercise after chemotherapy may also regain CRF and physical function to the same degree as those who started exercise during chemotherapy, which provides flexibility for patients unable to exercise. Exercise is also efficacious for improving fatigue, PROs, and other cancer-related symptoms in the setting of multimodality therapy such as chemoradiation.<sup>10</sup> Taken together, the extant data indicate that exercise may be implemented at nearly any point during the cancer treatment spectrum with favorable effects.

Adherence and tolerability are critical factors that impact the feasibility and efficacy of exercise therapy, perhaps even more so than pharmacologic therapies. For example, CRF recovery in patients who start supervised exercise after completing chemotherapy has been shown to catch up with that of patients who start exercise during chemotherapy but transition to home-based exercise after chemotherapy.<sup>10</sup> These findings suggest the superiority of supervised exercise over home-based exercise, though maintaining adherence can be a challenge. In this regard, smartphone mobile applications and other virtual/remote platforms could provide a scalable digital solution. Our group at Memorial Sloan Kettering recently demonstrated high engagement among survivors of breast cancer with a commercially

available smartphone application that led to an average weight loss of approximately 5% of baseline weight.<sup>11</sup>

In addition to smartphone applications, several existing web-based programs may be leveraged for patients with cancer. For example, the SurvivorSHINE program utilizes web-based diet and exercise counseling and has been shown to improve diet quality, increase physical activity, and reduce functional decline in cancer survivors.<sup>12,13</sup> The intervention consists of an interactive online program that has been subjected to rigorous formative research (focus groups, extensive beta testing, and stakeholder interviews) in diverse samples that informed and refined the yearlong intervention.<sup>14</sup> Website engagement data show weekly logins that are 2- to 3-fold higher than online lifestyle interventions of similar duration that are not tailored to oncology populations. Another important resource for implementing lifestyle interventions is the American Institute for Cancer Research, which offers continuous updates from published data and patient-facing educational information regarding diet and exercise.

Efforts are underway to include exercise oncology as a reimbursable service for cancer care. The success of such efforts stands to have a large potential impact on the availability and accessibility of exercise programs for patients with cancer throughout the US. Until exercise oncology programs become more accessible, it is our responsibility as oncologists to endorse the inclusion of exercise as part of cancer therapy and guide patients to appropriate resources. For now, the use of digital and web-based platforms provides an implementable and convenient approach to incorporating exercise therapy as part of whole person care in oncology. ■



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## LYMPHOMA

# Epcoritamab in Relapsed/ Refractory Follicular Lymphoma

In June 2024, the FDA granted accelerated approval to epcoritamab-bysp (Epkinly) for patients with relapsed/refractory follicular lymphoma after 2 prior lines of therapy.<sup>1</sup> The approval was based on results from the phase 1/2 EPCORE NHL-1 trial (NCT03625037),<sup>2</sup> which were recently presented at the 2024 American Society of Clinical Oncology Annual Meeting.

Prior to the approval, *ONCOLOGY* spoke with Tycel Phillips, MD, associate professor in the Division of Lymphoma and Department of Hematology and Hematopoietic Cell Transplantation at City of Hope in Duarte, California. Phillips spoke about the implications of approval and how this will impact treatment options in the space.

Topline results included an overall response rate of 82% (95% CI, 74.1%-88.2%) and a complete response rate of 60%. The median duration of response was not reached (NR; 95% CI, 13.7-NR). At 12 months, an ongoing response occurred in 68.4% (95% CI, 57.6%-77.0%). Two different cohorts were assessed—the pivotal and cycle 1, day 1 cohorts—where investigators analyzed the impact these different dosing regimens had on patients.

### Q / What does the approval of epcoritamab mean for this patient population?

**Phillips** / The biggest impact will be in centers that have picked 1 bispecific to keep on the formulary. Epcoritamab's approval in large cell lymphoma has allowed them to keep 1 bispecific agent or formulary and doesn't require them to have [multiple agents stocked].<sup>3</sup> In this situation, if they have a bispecific for diffuse large B-cell lymphoma [DLBCL] and an antibody specific for follicular lymphoma, it will require [the clinic] to have either epcoritamab,

glofitamab-gxbm [Columvi], or mosunetuzumab-axgb [Lunsumio] for follicular lymphoma.

This potentially allows for ease of use in that situation. There are fewer difficulties with staff [and] infusion nurses, [as well as not having to deal] with different bispecifics and being more comfortable with dealing with 1 drug. In the long term, it is always better for the patients because it's easier to manage the toxicity that may come from this. There is [also] more familiarity with the step-up of dosing for epcoritamab, which is different from what we have with mosunetuzumab and glofitamab.