Clinician Spotlight: Dr. Joshua Reuss

This month we have the honor of featuring Dr. Josh Reuss, Assistant Professor of Medicine at Georgetown Lombardi Comprehensive Cancer Center Washington, DC. Dr. Reuss participated in the 2021 EGFR Resisters Research Summit and was a 'Breakout Session' winner for his research on A Phase II Open-label Study of Tiragolumab plus Atezolizumab and Bevacizumab in Advanced TKI-refractory, ICB-naïve EGFR-mutated NSCLC. We are excited that Dr. Reuss was the recipient of a 2022 LUNGevity Career Development Award that will continue to fund this important research!

What motivated you to get involved with lung cancer research? How did you do it?
I was drawn to the field for two major reasons. First and foremost, the deep and meaningful connections you could form with your patients. Second, the incredible science that is driving therapeutic advancement in the field at a lightening pace. I applied to fellowship just as immunotherapy was breaking through the treatment landscape for solid tumors, and I really felt an excitement in the field. I found myself gravitating toward lung cancer due to the diverse array of treatment advances including both targeted therapy and immunotherapy.

What research have you done that would have the most impact on our members with the EGFR mutation?
A project that I am actively working on, and one which I received guidance on from members of the EGFR Resisters community, is a clinical trial that combines immunotherapy and anti-angiogenic therapy for patients with EGFR who have experienced disease progression on targeted therapy. There is a growing body of evidence that the addition of anti-angiogenic therapy may be important in stimulating an immune response.

What new projects are you working on?
I am working on several immunotherapy trials in localized and locally advanced NSCLC. I also have a strong interest in antibody-drug conjugates and am hoping to develop novel strategies that can combine these therapies with other agents to promote more durable treatment responses.

What was treating lung cancer/lung cancer research like when you first started to practice, and when was that?
I was fortunate to enter the field as a fellow right as immunotherapy was emerging into the treatment paradigm for advanced NSCLC, and after we had several subsequent generation targeted agents for EGFR-mutated, ALK-fusion and ROS1-fusion NSCLC. Over the course of fellowship and my three years as an attending thoracic oncologist, there has been a flurry of novel targeted agents entering the clinic, including those targeting MET, RET, and EGFR exon20. In addition, we have seen several treatment strategies that revolutionized treatment, such as immunotherapy and osimertinib

(Tagrisso), move to earlier stage NSCLC, which will hopefully lead to curing more patients.

What do you think lung cancer treatment will look like five years from now?
I hope it will become even more personalized. We need to be able to harness the incredibly complex and vast data obtained with next generation sequencing to determine the most appropriate treatment strategies for individual patients. It's a lofty goal, but one I think we can achieve.

What treatments/research of interest do you consider will make a significant impact in the not-too-distant future?
For EGFR, I suspect we will soon enter an era where more than just osimertinib is recommended at the beginning of treatment. The FLAURA2 trial, which explored the combination of osimertinib with chemotherapy, has reportedly demonstrated a significant improvement in progression-free survival with this combination. In addition, other therapies including antibody-drug conjugates and the bi-specific antibody amivantamab are being explored in combination with EGFR targeted therapies. These combinations will make therapy selection more complex but will hopefully help patients to live longer.

How could treatment be done differently at this time to improve care?
The only way we can provide a patient-specific approach to treatment is if we know the molecular make-up of a specific patient's cancer. This is getting better, but the number has to be 100%. This is critical.

Do you have any advice for people considering clinical trials?
The important thing to remember is that a clinical trial is almost always recommended for a reason. I tell my patients that I will only recommend a trial in the frontline setting if it builds on an existing standard-of-care and does not deprive my patients of a therapy that we know works. In addition, I will only recommend a trial in the subsequent line setting if the existing options are limited. Furthermore, I will not recommend enrolling in a trial if I am worried that waiting to begin therapy is not safe. The last thing I would say is that a clinical trial is COMPLETELY VOLUNTARY. One can consent to a trial and change one's mind and withdraw anytime.

Is there anything else you would like our readers to know?
While the focus of any physician-patient interaction is understandably geared toward the patient, for caregivers who are reading this, please remember to also care for yourself. The psychological, emotional, and physical stress you endure can oftentimes be overlooked. It is ok to take time for yourself and vital to maintain your physical and emotional health.