ICI Dissemination Challenges Highlighted at ASCO 2026

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> Despite the established efficacy of immune checkpoint inhibitors (ICIs) across numerous malignancies,1 their equitable dissemination and the consistent application of toxicity management protocols remain significant global challenges. Discussions at ASCO 2026 underscored that while innovation continues, the translation of these advancements into uniform clinical practice is lagging, particularly in resource-constrained settings.

KEY TAKEAWAYS

- The Pivot: Global disparities in ICI access and toxicity management are not diminishing at the pace of drug development.
- The Data: No specific trial data was presented, but the consensus highlighted a persistent gap between guideline recommendations and real-world implementation.
- The Action: Clinicians should advocate for standardised, accessible toxicity management pathways and participate in data collection to identify regional deficiencies.

Immune checkpoint inhibitors have fundamentally altered the treatment landscape for a growing number of cancers, including melanoma, non-small cell lung cancer, renal cell carcinoma, and various gastrointestinal malignancies.1 Their mechanism of action, involving the restoration of anti-tumour immunity, frequently results in immune-related adverse events (irAEs) that differ in presentation and management from conventional chemotherapy toxicities.2 Effective management of irAEs, ranging from dermatological and gastrointestinal to endocrine and neurological manifestations, is critical for patient safety and treatment continuation.3

However, the global oncology community continues to grapple with the uneven distribution of these life-extending therapies and the inconsistent application of evidence-based irAE management guidelines.4 This disparity is not merely an issue of drug availability; it extends to the infrastructure, specialist training, and diagnostic capabilities required to safely administer and monitor patients on ICIs.5

Dissemination and Toxicity Management Challenges

Discussions at ASCO 2026 highlighted that while the pipeline for novel ICIs and combination therapies remains robust, the focus is increasingly shifting towards implementation science.6 A recurring theme was the significant variability in access to ICIs, particularly between high-income and low-to-middle-income countries.7 This gap is exacerbated by the high cost of these agents and the complex regulatory pathways for approval and reimbursement.8

Beyond access, the consistent application of irAE management protocols presents a substantial hurdle.9 Guidelines from major oncology organisations, such as ASCO and ESMO, provide detailed recommendations for the grading

and management of irAEs, often involving corticosteroids and other immunosuppressants.10 However, real-world data indicate that adherence to these guidelines varies widely. Factors contributing to this variability include a lack of awareness among non-oncology specialists, limited access to diagnostic tools (e.g., specific hormone assays for endocrinopathies), and the absence of multidisciplinary teams equipped to handle complex irAEs.11

For example, immune-related endocrinopathies, such as hypophysitis or thyroid dysfunction, require prompt recognition and lifelong hormone replacement in some cases.12 Similarly, immune-related colitis or pneumonitis can be life-threatening if not managed aggressively with high-dose corticosteroids and, in refractory cases, infliximab or vedolizumab.13 The ability to rapidly diagnose these conditions and initiate appropriate treatment is often contingent on the availability of specialist endocrinologists, gastroenterologists, or pulmonologists, which is not uniformly present across healthcare systems.14

The lack of standardised patient education on potential irAEs also contributes to delayed presentation and increased severity.15 Patients in settings with less robust follow-up infrastructure may not recognise early symptoms, leading to more advanced and harder-to-manage toxicities.16 The need for digital health solutions and telemedicine to bridge these gaps was frequently discussed, particularly for remote monitoring and specialist consultations.17

The patient populations most affected by these disparities often reside in rural areas or regions with underdeveloped healthcare systems. These individuals may face significant travel burdens to access specialized oncology centers, further delaying diagnosis and treatment of irAEs. The complexity of ICI administration and monitoring necessitates a well-coordinated healthcare team, including oncologists, nurses, pharmacists, and various subspecialists, to ensure optimal patient outcomes. The absence of such integrated care models in many regions represents a critical limitation in the widespread and safe dissemination of ICIs.

Furthermore, the long-term implications of untreated or inadequately managed irAEs can significantly impact patient quality of life and survival, even after successful cancer treatment. Chronic endocrine deficiencies, for instance, require ongoing management and can affect daily functioning. The economic burden associated with managing severe irAEs, including hospitalizations and specialized medications, also poses a challenge for healthcare systems, particularly in resource-limited settings. Addressing these systemic issues requires a multi-faceted approach that considers not only drug accessibility but also the entire ecosystem of care surrounding ICI therapy.

The consensus from ASCO 2026 was that while the scientific community continues to push the boundaries of ICI efficacy, a concerted global effort is required to ensure that these innovations reach all patients who could benefit, accompanied by the necessary support systems for safe and effective toxicity management.18 This includes investing in training programs for healthcare professionals, developing more affordable treatment options, and establishing robust data collection systems to monitor real-world outcomes and identify areas for improvement.19

For further insights into contemporary oncology and addressing challenges in patient management, refer to the Oxford Handbook of Oncology.

> **CLINICAL IMPLICATIONS**
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> The persistent global disparities in immune checkpoint inhibitor access and toxicity management, highlighted at ASCO 2026, are not merely an academic concern; they represent a tangible barrier to optimal patient outcomes. It is a stark reminder that the pace of drug development has far outstripped the rate at which

> healthcare systems can adapt, particularly in resource-constrained environments. The industry, while laudably innovating, must now pivot some of its considerable resources towards implementation science, ensuring that the promise of these therapies is realised beyond the confines of well-funded academic centres. Merely developing a drug is insufficient if half the world's population cannot access it or manage its predictable side effects.
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> Clinicians, especially those in general practice, bear a significant burden here. They are often the first point of contact for patients experiencing immune-related adverse events, yet they may lack the specialist knowledge or immediate access to diagnostic tools and subspecialty consultation that guidelines recommend. This necessitates a more proactive, integrated approach to education and referral pathways. Professional bodies like ASCO and ESMO have published excellent guidelines, but these are only effective if they are disseminated, understood, and actionable at every level of care. Perhaps a simplified, tiered approach to irAE management, tailored for different resource settings, is required, rather than a one-size-fits-all ideal.
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> For patients, the implications are profound. Unequal access means unequal chances at life-extending treatment. Furthermore, even when access is granted, inadequate toxicity management can lead to severe morbidity, treatment discontinuation, and even mortality, negating the very benefits of the therapy. This is not just about drug cost; it is about the entire ecosystem of care. Payers and policymakers must recognise that the investment in ICIs must be accompanied by commensurate investment in the supporting infrastructure, training, and multidisciplinary teams. Without this holistic approach, the 'innovation' remains largely theoretical for a significant portion of the global patient population, a luxury rather than a standard of care.

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