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Accurate Staging and Determining Resectability in NSCLC

Announcer:
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Dr. Reuss:
Hello, my name is Dr. Joshua Reuss. This is CME on ReachMD, and today we'll be discussing accurate staging in determining resectability in non-small cell lung cancer. Really pertinent and important topic.

So in my practice, when I am encountering a new lung cancer patient, particularly one that's not metastatic, this is our first question: Is this a patient where we can undergo curative-intent surgery, or is it a patient where we have to pursue a definitive chemoradiation approach in someone who does not have resectable disease?

So how do we go about making that determination? So staging is super important here. You know, oftentimes these are patients that have had lung cancer screening where they've encountered a new lung nodule, a new lung lesion. We'll sometimes see them even before there's pathologic confirmation. So in that setting, I'm talking to my pulmonologist while concurrently completing the staging. What's critical here? Contrasted diagnostic CT scans of the chest, abdomen, pelvis, in addition to a PET/CT. We know that non-small cell lung cancer likes to travel to bone, to lymph nodes, to liver, adrenal glands, though no cancer reads a particular playbook, so we really have to look to see if there's cancer that has spread elsewhere. In addition, a brain MRI is important because lung cancer can spread to the brain, and both CT and PET scans are not the best modality to look at the brain.

So in terms of imaging staging, those are all very important steps, but then pathologic staging is super important. If there is no concern for metastatic disease, then I'm talking to my interventional pulmonologist to do both a diagnostic and staging bronchoscopy, not only to obtain tissue from the concerning lung lesion, but to really stage the mediastinum. Are there other lymph node stations that are involved that affect stage? Unfortunately it's far too common that I'll receive a new diagnosis in which a patient had a CT-guided biopsy of a lung nodule, and while that might get you a diagnosis, it does not confirm staging. And so that is very important.

So that was very important in first determining disease stage because, for example, if there's occult multistation N2 lymph nodes, or perhaps a contralateral lymph node N3 disease, particularly in those scenarios, we're primarily already going to chemoradiation because those are patients that aren't typically deemed resectable. But in cases where there's N2 lymph node involvement or multistation N2, that's where the multidisciplinary discussion is super important. That is where I'm talking with my surgeons, with all my radiation oncologists, all members of the team to say is this someone that is deemed resectable right now? We know that there's been an optimization of the perioperative systemic therapy approaches in resectable non-small cell lung cancer, though we should still not be giving these medications to downstage and convert a patient from unresectable to resectable disease. We really don't have data in that space. We should really be determining resectability up front.

So that's a very important discussion. And in addition to determining resectability on imaging, obviously one needs to look at the patient,

talk to the patient. Is it someone who is fit for surgery? What is their pulmonary function? What do their PFTs [pulmonary function tests] look like? What's their cardiac function? Is it safe to move forward with a surgical procedure? So these are all very important diagnostic and assessments that need to be entertained in order to determine the most appropriate treatment for a patient, whether that's up-front resection or resection following neoadjuvant therapy, or instead, pursuing a definitive chemoradiation approach with either sequential or concurrent chemoradiation.

So with that, I know that was a lot of information coming at you very quickly. I think the key points are here, making sure all staging and diagnostic steps are done to really accurately determine the stage of the cancer and communicating with other key team members, surgeons, radiation oncologists, to determine the most appropriate treatment modality for your patient.

So with that, I want to thank you for your attention and look forward to ongoing discussions.

Announcer:
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