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Guidelines in Flux – Making Sense of the Shifting Local Standards

Announcer:
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Dr. Cho:
Hello everyone. This is CME on ReachMD. I'm Dr. Cho. Here with me today is Dr. Leighl and Dr. Kerr.

Now we are going to take a closer look at how guideline recommendations are changing for metastatic NSCLC.

Dr. Leighl, what are we seeing across recommendations from ESMO, the NCCN, and IASLC?

Dr. Leighl:
Thanks so much. So as you know, one of the challenges with guidelines are they often take a very long time. And so with living guidelines, we've tried to make that process much faster. So the NCCN has really always had this living update or real-time update process. Now ESMO has this process, and ASCO also has this process. And so what that leads to is, of course, some incorporating all of the latest data and then some guidelines that lag behind.

So for example, if you look at the ESMO living guidelines, that has amivantamab–lazertinib first line, osimertinib and chemotherapy, osimertinib alone. Similarly for the NCCN and the ASCO living guidelines. But if you look at old published guidelines—for example, the 2023 guidelines from ESMO or the IASLC—where you haven't kept these current, these new data don't emerge.

And so I think it's really important that clinicians understand that you really need to look for the latest version of these guidelines. If an organization has a living guideline, you need to get yourself tapped into that.

Now the other challenge, of course, with guidelines that we've really seen is just because you say it's the latest and greatest doesn't mean that's available to everyone. And some countries are still using first-generation and second-generation EGFR kinase inhibitors. So how do you design one guideline that meets everyone's needs? And that's very, very hard.

I think NCCN has a nice way of doing that, where they say what's preferred, and then there's everything else. ESMO, I think to some extent, has tried to move with the latest. And then with ASCO, we've also tried to move with the latest guidelines. But it's become very clear that if you're going to use these in certain countries where only generic agents, for example, are available, and they require those guidelines to get them to patients, we really do need to be more inclusive.

And so I think whether it's in the appendix or whether it's a preferred set of regimens, if you can afford them, we really do need to think about how do we make guidelines accessible to all patients in all countries and make them truly global. And so these sort of resource stratification processes, I think they change every year. We're trying to make it right, but hopefully as these global guidelines are something that you can apply locally, we'll start to see these newer treatments emerge—amivantamab and lazertinib, osimertinib and chemotherapy, other third-generation TKIs—and then also subsequent therapies moving up from platinum.

Dr. Kerr:
Yes, I think that Dr. Leighl has made many important points, and I'd just like to pick up on 2 of them. It's certainly also been my experience in being involved with guidelines, that it's really difficult to keep up to date with the traditional approaches that have been taken to writing guidelines. So moving on to a living guideline is very important.

The other issue is around access. And not everyone, in a global sense, has access to the same testing technology, for example, so that the guideline has to be broad-minded enough to consider best practice in those parts of the world where access, say, to next-generation sequencing or other advanced technologies, ctDNA testing included, might be quite difficult.

Dr. Cho:
One more comment from me is that treatment of EGFR-mutant lung cancer is a really rapidly evolving field. We have a lot of information coming up to date. So I think it's really difficult to incorporate all these up-to-date new information in all the guidelines. But in order to give best practice to our patient in our daily practice, it's really important: the most up-to-date information that can be practice-changing should be incorporated in the current practice guideline as quickly as possible.

With that, our time is up. Thanks so much for further listening. Thank you.

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