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The Treatment Symphony – Coordinating Multidisciplinary Care for Best Outcomes

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

Dr. Cho, can you share your perspective on coordinating a multidisciplinary care team for our patients with EGFR-mutated non-small cell lung cancer?

Dr. Cho:
Sure. MDT is a process of gathering intellectuals of multiple experts. MDT usually consists of oncologists—medical oncologists, surgeon, pathologist, pulmonologist, and radiation oncologists.

I believe MDT is becoming more important because treatment is more and more complex in EGFR-mutant lung cancer. So we have diverse treatment options in both early-stage EGFR-mutant lung cancer as well as advanced-stage EGFR-mutant lung cancer.

When it comes to advanced-stage lung cancer, more and more intensifying combination regimens are becoming available such as the FLAURA2 regimen or MARIPOSA regimen. So these combination regimens always come with increased toxicity. For example, amivantamab has infusion-related reaction, skin rash—all these complications should be managed well to make patients remain on treatment for a long time, which eventually contributes to improved outcome.

So in addition, I think several clinical trial data support use of SBRT or a debulking surgery on top of EGFR TKI in advanced-stage EGFR-mutant lung cancer can further improve survival outcome.

So all these therapies, including SBRT and surgery, should be discussed in MDT, even in stage IV EGFR-mutant lung cancer.

Dr. Leighl:
That's great. In Toronto, we've also added a level of the diagnostic MDT, where through our rapid diagnostic program, we have our interventional radiologists, surgical expertise, medical oncology, radiation oncology, pathologists, radiologists, and all of this is led by a nurse practitioner who runs our rapid diagnostic program so that we can figure out: Who's got advanced disease? They need tissue; do they also need a liquid biopsy? Who's got early stage? Who needs to be prioritized for that early-stage MDT discussion? Where do we need to prioritize the biomarkers? What do the pathologists need to be looking for, or where can we reflex to plasma testing to get that answer faster and really get patients to the best possible care.

You never want to have patients waiting in the queue, someone saying on the other end of a piece of paper or a fax, oh, we're going to wait till we get their biomarkers, when the patient desperately needs radiotherapy or desperately needs to start chemotherapy or needs to be discussed urgently at MDT. So we've really tried to use that, and it's really been a great way to sort of increase that

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multidisciplinary discussion.

Dr. Kerr:
Yeah, I think there are many advantages to having a multidisciplinary team and to have that regular discussion about managing our patients with non-small cell lung cancer, and in particular those with EGFR-mutant disease.

I think one of the advantages of the multidisciplinary nature of this discussion is an educational one—an ongoing educational advantage—everybody in the team understanding and learning about the newest developments and what their role in the ever-changing landscape of managing these patients might actually be.

And I think that understanding of the process and their role helps to get people engaged in their bit of the pathway. And this can only lead to a better service, a better quality of service, and indeed, a faster service to deliver the best results for our patients in the shortest period of time.

Well, this has been a great discussion, I hope. Our time is up, and thank you very much for listening.

Announcer:
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