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TRANSCRIPT

Transcript Details
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NSCLC: An Aggressive Approach for Personalized Therapy

Announcer:
This is ReachMD, and you're listening to *Closing the Gaps in NSCLC,* sponsored by Lilly.

On this episode, titled *Approaches in Aggressive Disease Management,* we will hear from Dr. Ross Camidge from the University of Colorado.

Dr. Camidge:
On the topic of aggressive disease management for advanced non-small cell lung cancer, you can interpret the issues associated with that in a number of different ways. So, one is, obviously, if you can find a way of personalizing therapy by finding out what's driving their cancer, so much the better, so that's about sending off a broad molecular testing panel and pushing hard to say you do or you don't have a driver oncogene. The second thing is recognizing that whatever systemic therapy you start on, that we have become much more aggressive about the use of ablative radiotherapy, and occasionally surgery, even outside the envelope where we normally started to use it.

So, many of you may have heard of the term oligometastatic disease, which is a small number of sites of disease when you walk through the door with diagnosis, but we now have 2 other terms which have come in. From 2012, we've had the term oligoprogressive disease. So you could have had a zillion sites of disease to start with, you go on a therapy, often a targeted therapy, and it controls most of the disease, and then at some point in the future, through clonal evolution, perhaps only a single site is growing, and there you can stay on the targeted therapy and zap that area with local radiotherapy. Doing it in the brain is the obvious example, but you could actually do it in the body—a single bone or, a single lymph node—and the key thing is to use ablative doses of radiotherapy. You're not trying to palliate something. And that we can see can double the duration of control for some of these drugs.

The most recent concept is the concept of oligoresidual disease, and this is somewhere between those 2 extremes. So you have a certain number of sites of disease when you walk through the door. You go on some kind of therapy, could be chemotherapy, and then at the point of maximal response—so 2 scans looking about the same—you don't have much disease left. But it's not growing, so it's not oligoprogressive. It's oligoresidual disease. And a nice study led from MD Anderson and then with the University of Colorado and London, Ontario showed if you ablated 3 to 4 sites of residual disease, you improved survival; you improved the time to distant metastatic new sites of disease. Again, the logic is simple. If the stuff that is residual, that's where later growth occurs. So this is the beginning of a much more aggressive and evidence-based management of trying to keep the patient alive with the patient in a dominant position and the cancer in a submissive position.

Announcer:
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