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The Role of Primary Care in Diagnosing NSCLC

Announcer:
This is ReachMD, and you're listening to Closing the Gaps in Non-Small Cell Lung Cancer, sponsored by Lilly.

Dr. Russell:
Sharp chest pain, chronic cough, respiratory infections, and loss of appetite. These are all early symptoms of non-small cell lung cancer. Most patients with lung cancer present with these symptoms, initially to their primary care practitioner, and if it is diagnosed early enough, this can increase the rate of survival. So how can primary care practitioners work with oncologists during this diagnosis phase to get these patients to treatment faster?

Welcome to Closing the Gaps in Non-small Cell Lung Cancer on ReachMD. I'm Dr. John Russell, and joining me today is Dr. Mark Sundermeyer, the Deputy Chief of Hematology and Oncology at Abington Hospital, Jefferson Health, to talk about how primary care plays a vital role in the diagnosis journey for patients with nonsmall cell lung cancer. So, Dr. Sundermeyer, thank you for being on the show today.

Dr. Sundermeyer:
Thanks for having me.

Dr. Russell:
So, lung cancer remains the number one cause of cancer throughout the United States, correct?

Dr. Sundermeyer:
That is correct.

Dr. Russell:
So, as a primary care doctor, what are some of the signs and symptoms I should be thinking about in the patients I am seeing, who may have lung cancer?

Dr. Sundermeyer:
They can start off from very subtle to very specific. And the things that you think about first are the patient that comes in with some shortness of breath, or a little bit of weight loss or loss of appetite. Then it can get really specific; that focal chest pain, coughing up blood, even unusual symptoms like a droopy eye, or something that results in leg pain can sometimes be a subtle signal for something that is going on.

Dr. Russell:
But by the time someone has signs and symptoms of lung cancer, your job as an oncologist is very difficult, correct?

Dr. Sundermeyer:
Correct. Unfortunately, lung cancer, once it causes symptoms, really is typically a later stage, like a Stage III or IV. As a result of that, there have been numerous studies looking at ways of screening patients to catch those cancers earlier.

Dr. Russell:
So, historically, when they looked at screening for lung cancer, it really wasn't all that successful, correct?

Dr. Sundermeyer:
Correct. And that was using older technology like chest x-rays, which are very nonspecific. So there was a large study that came out a

few years ago that looked at screening CAT scans to really catch those cancers earlier. And the trick to success with that was really identifying the right patient populations. Those smokers in the right age group really guide you into making a screening study successful.

Dr. Russell:
So in this study looking at CAT scans and lung cancer screening, what did they find in that study? How much of a difference did it make?

Dr. Sundermeyer:
This was one of the times where a screening study was found to be very successful. We really hold ourselves to the standard of, does a screening test save lives or reduce the risk of death. And that has been hard to prove for other screening studies, but in this study, they were able to show that there was a 20% reduction in risk of death.

Dr. Russell:
Wow. So how often will I be screening my patients with a CAT scan?

Dr. Sundermeyer:
So that would be initially once a year. And the study was done on an annual basis for three years, but the current guidelines are really to continue as long as they are within that risk group up until the age of 77.

Dr. Russell:
So, say I have a patient who got screened and has a very abnormal-looking CAT scan. As a medical oncologist, do you think it's someone I should be working up and doing PET scans and doing cytologies, or should early referral make a whole lot of sense for them?

Dr. Sundermeyer:
So, I kind of leave it a little bit to the primary in terms of what they feel comfortable with. We are pretty used to a quick hand-off and kind of taking the lead from there. But I have some primary physicians that really like to get the ball rolling and do the CAT scan, the follow-up, and getting the PET scan done and referring to pulmonary before they need me as the actual cancer specialist. But we have kind of a quick hand-off program here where we can take the reigns and get that done quickly, as well.

Dr. Russell:
So, you talked about a CAT scan protocol. Who would be the patients I would be referring on for lung cancer screening?

Dr. Sundermeyer:
So there are two different cohorts that we have been looking at, but the one best described is really the patient's age of 55 to 77 that are an active or former smoker that had about a 30-pack-year smoking history. And those are the patients we think are most likely to benefit from this screening protocol of a once-a-year low-dose CAT scan.

Dr. Russell:
So you've been an oncologist for quite awhile now, and I think you've seen a transition a little bit in the diagnosis of lung cancer. And I know you have a great interest in genomics. How has genomics kind of changed and reframed lung cancer treatment and approaches?

Dr. Sundermeyer:
So, when I initially began practicing, lung cancer was very straightforward. Once it was diagnosed, it was surgery, radiation or chemotherapy. But with the advances in genomics and molecular targeting, it has really changed everything that we do. And then along came immunotherapy, and it has really exposed us to new options and opportunities. And it used to be that you could simply have a biopsy, and then I would then know what to do. Now I'm waiting for molecular diagnostics to come back, because the first treatment is very critical to choosing where we go with treatment.

Dr. Russell:
And I think oftentimes when people have such a profound diagnosis, they feel they have to move much more rapidly, and probably getting these tests back is not the next day.

Dr. Sundermeyer:
It is not speedy. And you know, one of the most difficult parts with the lung cancer diagnosis is that waiting in between meeting the lung doctor, getting your bronchoscopy, getting your tissue, getting your PET scan, and that is a really challenging time for patients. So, these molecular tests can take up to two weeks to come back after the biopsy is obtained. So we started a process where you automatically reflex those tests so they are started from day one, as opposed to waiting for someone to order them. And we use our navigators pretty robustly during this time period to keep in touch with patients, and let them know that everything is moving along, heading in the right direction, and that the workup is progressing.

Dr. Russell:
So, with the new lung cancer diagnosis, what are some of the other things you're doing in the workup, maybe while you're waiting for the tissue to come back?

Dr. Sundermeyer:
So, there are a couple of things. One is, for certain treatments, you have to start some vitamin supplementation. So you will start that for a week before you start treatment. You will be completing studies like brain MRIs to make sure you know that the staging is fully complete. And there are certain procedures that you do just as safety checks; looking at basic organ function, seeing how healthy the patient is, communicating with their other doctors about their other health issues, because using treatments, for example like immunotherapy, can be very problematic for someone that has ulcerative colitis or rheumatoid arthritis. And sometimes it takes a little bit more effort and digging to be sure that the first treatment is the right treatment for that patient.

Dr. Russell:
So, we talk a lot about individualizing care, and I guess genomics is the ultimate way to individualize care. What about this team approach - I think you're kind of talking about lots of people on the team; how important is that in today's day and age?

Dr. Sundermeyer:
So, it's very important because there are so many different modalities, and it's hard to be an expert in all of them. So we utilize our radiation colleagues very regularly, and we have these multidisciplinary conferences where we kind of pull together 10 medical oncologists, the surgeons, the radiation doctors, the pathologists, the radiologists to really make sure 20 people agree that we are on the right track. And those conferences are very useful and comforting to patients, because diagnoses like lung cancer are much more overwhelming than more straightforward diagnoses. And having that team support is very useful. We offer then virtual multidisciplinary clinics where they can see different doctors on different days, or we actually offer then same-day appointments where they can see myself as a medical oncologist, a radiation oncologist, and a surgeon all in the same day if they want to. We have found that can be a little overwhelming for patients; it's a long day. We have expedited appointments where, if you have a lung nodule, you can see the pulmonologist within 48 hours. We offer next-day appointments, as does radiation, which can really move things along for a patient.

Dr. Russell:
So for that oncologist in Anytown, USA, though, they might not have that whole team available in their town. With genomics, with the new things that we know about lung cancer, is it very protocol-driven anymore?

Dr. Sundermeyer:
It is, basically. So there are really strict guidelines about how best to manage a patient, and you don't need 100 people to tell you how to do it, you know; as long as you're knowledgable about the treatments and how to utilize them, you can do it on your own, as well. And you need communication more than you need a room full of people. So it's just as easy to pick up the phone and talk to a subspecialist as it is to

Dr. Russell:
So you talked about team-based care, and we talked a lot about physicians; who would be some of these other people ideally on this team for this particular patient?

Dr. Sundermeyer:
Yeah, I think that's really important. The challenges of going through cancer treatment can be financially and emotionally draining. Some of the tools that we utilize are financial counselors for co-pay assistance, and getting access to the drugs, but also social workers for family support, as well as dieticians for nutrition counseling, and even something as simple as talking to the patient about exercise or how they take care of themselves as they go through treatment. Those extra resources can really take a bit amount of the burden off the patient.

Dr. Russell:
We talked a lot about lung cancer treatment, but prevention of lung cancer is still pretty important, and smoking cessation is still a pretty important thing that primary doctors should be doing, correct?

Dr. Sundermeyer:
Absolutely. It is very important, and you know, unfortunately for those patients that we do catch early and take through treatment, they have as high as a 50% chance of getting a second lung cancer. So motivating them to stop smoking, using smoking cessation counselors, medication agent are absolutely critical to preventing them from the next cancer.

Dr. Russell:
Is there anything you would like to share with the primary care audience that I should be expressing to my patients with a new diagnosis

about lung cancer?

Dr. Sundermeyer:
I think one of the things is that a lot of times when patients start treatment for lung cancer, they kind of drift away from their other doctors and get sucked into the vortex of oncology. I really encourage them to keep in close contact with their other doctors, because a lot of the treatments that I use can really have an impact on their global sense of health, and having the primary care doctor closely involved is absolutely critical. If something unusual shows up, and the patient goes to the primary care doctor, they should also call me to figure out whether it is something weird that I might have done to the patient.

Dr. Russell:
Well, you have certainly given us a lot to consider. I want to thank my guest here, Dr. Mark Sundermeyer, for joining me today to discuss the keys to success when it comes to diagnosis nonsmall cell lung cancer in a primary care and oncology partnership. Thank you so much for being with us today.

Dr. Sundermeyer:
Yes, my pleasure. Thanks for having me.

Announcer:
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