

Transcript Details

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The Significant Search for Diagnostic Accuracy in NSCLC

Announcer:

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

Dr. Caudle:

When it comes to creating treatment plans for non-small cell lung cancer, it's important to know that while certain factors like whether or not a patient smokes do impact these decisions, it's based primarily on the stage of the cancer, which brings us to the focus of today's discussion. How can we ensure that we're accurately diagnosing these patients so that they receive the proper care?

Welcome to Closing the Gaps in Non-small Cell Lung Cancer on ReachMD. I am your host, Dr. Jennifer Caudle, and joining me to discuss the keys to diagnosing and treating the various stages of non-small cell lung cancer is Dr. Erin Schenk, an Assistant Professor of Medical Oncology at the University of Colorado.

Dr. Schenk, thanks so much for being here today.

Dr. Schenk:

Glad to be here.

Dr. Caudle:

So, let's just dive right in, Dr. Schenk. What would you say are the keys to an accurate diagnostic staging of non-small cell lung cancer, or NSCLC?

Dr. Schenk:

So, I think number 1, of course, is finding the cancer as soon as possible. And as a medical oncologist, when someone comes to my office with a new diagnosis of lung cancer, some of the important things that I look for, number 1, are a biopsy to tell me what type of lung cancer or non-small cell lung cancer that I'm dealing with, and number 2, what sort of imaging do I have on hand. And then, also, it's very important for me to get imaging of the brain. In patients with a new diagnosis of lung cancer, there is a significant proportion of patients who do have brain metastases at diagnosis, and that's important for me to know right away.

Dr. Caudle:

Now, false positives are an unfortunate reality, so how do you address the issue of false positives in CT-based screening, and what strategies do you recommend to help us really get an accurate diagnosis?

Dr. Schenk:

That's a great question because this is something patients will very reasonably ask. "What's the likelihood if you find something it's real?" And with the low-dose CT scanning, that CT scan that the patients get is not as detailed as a diagnostic CT scan, so it's more of a quick look rather than a very detailed look. Let's walk through this for a patient. For example, they have a low-dose CT scan, and there is something that's seen that needs to have follow-up, and most commonly all the patient needs is another CT scan, meaning they just need a diagnostic CT scan, so one that's a little more detailed sometimes with or without contrast to really get a better sense of what that nodule or what that area of concern was. Sometimes patients will also need a PET scan, which is a different way of looking at nodules, because what that PET scan can tell us is that if the area on the PET scan and that area of concern is very, very bright, which is sort of the readout of the PET scan, that is more suggestive of a cancer, but if it's not bright, if it kind of looks like the same level of other tissues, then that's more suggestive that it is likely benign. Of course, the ultimate need is for a biopsy, so if those additional scans don't give you a clear answer, one to say, "No, those are benign, we can just watch that," then a biopsy, of course, is needed.

The other piece I would like to put in is that CT scanners have become much more sophisticated, even the low-dose CT scan, and our ability to understand what exactly these nodules are has also become much better in the years that have followed since the first study that told us the CT scans are helpful in diagnosing patients. And this was, of course, 10 years ago. If you think how advanced your phone was 10 years ago, that sort of gives you a sense of how more advanced our CT scans are now. So, my hope is moving forward perspective that the false positives will be less of an issue—still an issue, but less of an issue.

Dr. Caudle:

Based off of your own experiences, when you are planning treatment for your patients with stages I and stages II non-small cell lung cancer, what's your particular approach? Are there certain considerations that play a role in the decisions that you make?

Dr. Schenk:

Absolutely. The difference between stage I and stage II often has to do with the size on the scans, how big these tumors look based on the imaging, and also, whether or not there may be some local lymph nodes involved. So, if things are a little bit bigger and there might be a few lymph nodes near the tumor that appear to be involved, that would make it a stage II.

So, initially, my first thought with these early-stage patients are, "Can I get them to a surgeon?" And what that means is: Are these spots where the disease appears to be, does that appear amenable to surgical excision? And also: Is my patient healthy enough to do this surgery? Often these are questions I discuss together with the surgeon, and they often make the final decision of whether or not surgery is an option for these patients. So, for example, if they can't have the surgery because they are in poor health otherwise or for other reasons they can't undergo that therapy, then also we can consider sending them to a radiation oncologist, because local ablative radiation therapies are also quite good at controlling the area of cancer and also at bringing about cure, but the gold standard really is surgery. Once the surgery is done, another important factor as to whether or not any additional treatment is done is the pathology report and whether or not lymph nodes near the middle of the chest are involved, because if lymph nodes are involved or the tumor might be bigger than we even thought initially, that's when I would have a discussion with the patient about chemotherapy after the surgery or adjuvant chemotherapy.

Dr. Caudle:

So, before the break, Dr. Schenk, we talked about your treatment approach for stages I and II non-small cell lung cancer, but what if a patient's disease progresses to stage III or IV? How would that change your approach?

Dr. Schenk:

So, if a patient is stage III, that becomes very complex, because one patient's stage III is not necessarily another patient's stage III. And what I mean by that is that there are so many different ways a patient can have a stage III disease. They can have a really large primary tumor and we push them in a stage III category because it's involving other structures in the chest, or they can have a stage III cancer, not because the main tumor is so large, but because there are a lot of lymph nodes in the middle of the chest involved. For stage III, I still try to figure out a way with, of course, my surgical colleagues, can we get this patient to surgery. That's still a very important piece of curative intent therapy. But if they are not able to undergo surgery just because of where the location of the tumor is or other health factors, we often treat them with a combined approach of chemotherapy and radiation therapy. And then after that combined approach, we give them immunotherapy.

In terms of stage IV disease, now that's a different approach. Some of the information that's very important to me as a medical oncologist taking care of patients with stage IV or metastatic disease is, number 1: Where exactly is the disease located? Are they stage IV because they have a single lesion in the brain, or are they stage IV because they have multiple tumor areas throughout the bone? That's sort of some of the initial assessment that I do. And then another piece of information that is very important is a number of studies we do on the tumor tissue itself. So, in non-small cell lung cancer, in about 20% of the patients who are new diagnosis, I have the opportunity to actually just give them a pill, because there are certain genetic molecular drivers that are responsive to targeted therapies that we have available. Also, what's important to know is their status for immunotherapy, and that's something we look for on the tumor tissue itself, because there are certain patients where I don't treat them with chemotherapy up front, so those patients that have the genetic changes that I can give them the pill, and there's also patients where I can give them immunotherapy alone, and that's dependent on what information we can get from the tumor tissue.

Dr. Caudle:

Obviously, non-small cell lung cancer is a difficult disease to manage, and you've just been talking about the complexities of managing it. How can we keep our patients really at the center of our approach to care?

Dr. Schenk:

I think it's very important for patients to know what exactly do they have—meaning this is lung cancer, what type of lung cancer it is—so that's kind of first piece. The second important thing that I want patients to know is what therapies are available, because there are a

multitude of potential treatments that I can offer to patients that are very, very different but are personalized based on what I see from the tumor tissue. And I think the final piece—and this is often where patients do or do not want to know the answer—but I always offer to tell them how effective the therapies are that I could potentially give them, and often this discussion becomes about survival and prognosis. Sometimes patients really want to know what it is they are facing in terms of is this curative or noncurative, and if this is noncurative, how long do I expect them to live, but sometimes it's just not something they want to get into right away, which is reasonable. These answers and these questions are something I'm always happy to revisit during a patient's disease course and when I take care of them, and I always tell them, "This isn't your only opportunity to ask questions. You'll see me every couple of weeks. I'm happy to readdress these things at any time."

As patients go through therapies, I think what's also really important is recognizing that as a medical oncologist we do our best to get our patients to live as long as possible and as well as possible, and sometimes that means initiating discussions where we talk about how therapies really aren't doing what we would hope and having a very honest and compassionate discussion about what to expect from therapies as we get kind of through first-line, second-line, third-line, and offering the option of maximizing quality of life for as long as possible by implementing palliative care.

Dr. Caudle:

Well, that's been really helpful, certainly for me as a family doctor, and I know that all of our healthcare providers listening and others will find this very helpful. Before we close, Dr. Schenk, are there any other insights that you would like to share with our audience today?

Dr. Schenk:

Definitely. Lung cancer, deservedly so, is a very scary diagnosis, especially if it's a patient that you've been taking care of and going through life with in sort of a primary care situation. And on the medical oncology side, more or less there has been a revolution going on. I have many tools to help your patients live longer and better than even 5 years ago, and so, while it is a devastating diagnosis, it is very important that when the diagnosis comes about, to send the patients to a medical oncologist to talk about therapies available, because there are people even with metastatic lung cancer that we can help live—we can help them live for years. Of course, that's not everyone, but it's a significant proportion of patients that we can help for a long time, so that's the first piece of information I'd like to convey.

And finally, the last point, and this is a line I like to use for everyone, "You can forget everything else I have said, but please talk to your patients about screening for lung cancer." I have many tools in my toolbox, but I cannot cure—in general, I cannot cure patients with lung cancer. The people with the real tools to cure lung cancer early on are those who screen for lung cancer. You guys can do a much better job than I can.

Dr. Caudle:

That's a great way to round out our discussion on the various factors that can impact our approach to treating patients with non-small cell lung cancer. And I'd like to thank Dr. Erin Schenk for joining me today. Dr. Schenk, it was great having you on the program.

Dr. Schenk:

Yeah, great to talk with you today.

Dr. Caudle:

I am your host, Dr. Jennifer Caudle, and thanks for listening.

Announcer:

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