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Best Practices for Curative-Intent Concurrent Chemoradiation Therapy in Unresectable Stage III NSCLC

Announcer:
Welcome to ReachMD. This medical industry feature titled “Best Practices for Curative-Intent Concurrent Chemoradiation Therapy in Unresectable Stage III NSCL” is sponsored by AstraZeneca. This program is intended for physicians. Here’s your host, Dr. Jennifer Caudle.

Dr. Jennifer Caudle (host):
Coming to you live from the ASTRO Annual Meeting in Chicago, Illinois, I am your host, Dr. Jennifer Caudle, for ReachMD. Here with me today is Dr. Kristin Higgins, Medical Director of Radiation Oncology at Winship Cancer Institute of Emory University in Atlanta, Georgia. She’s going to share her perspectives on the benefits of curative intent therapy in patients with unresectable stage III non-small cell lung cancer. We’ll also explore the role of radiation oncologists during treatment with concurrent chemoradiation therapy as well as best practices based on Dr. Higgins’ experience.

So, Dr. Higgins, welcome. Thank you so much for being with us today.

Dr. Higgins:
Great, thanks for having me.

Dr. Caudle:
Absolutely. So, to start off, can you please share your perspectives on the goals of treatment for unresectable stage III non-small cell lung cancer?

Dr. Higgins:
Sure. So, it’s important to remember that stage III patients should be treated with curative intent.

The goal of radiation and chemotherapy is to eradicate the tumor and the involved lymph nodes, and then if a patient does not progress, they are eligible for guideline-recommended immunotherapy. It’s also important to remember that radiation techniques have evolved so much over the last several decades. Our treatments have gotten safer and better tolerated. We’re able to deliver full-dose radiation to tumors in different locations that were untreatable years ago because of our advanced technologies, and we’re able to deliver this curative intent treatment to older patients, patients that have other medical comorbidities like COPD or heart disease and things like that, so really, stage III disease should be treated with curative intent.

Dr. Caudle:
Absolutely, and that’s really helpful information, you know. Now that we’ve discussed a little bit about the treatment goals in this setting, let’s talk about the techniques that you use to provide patients the best opportunity for optimal outcomes. So, what are some of the techniques that you use when treating with concurrent chemoradiation therapy, and can you share some examples, any real-life patients, perhaps, who have had unique considerations for chemoradiation therapy and the ways in which you were able to treat them and get them through treatment?

Dr. Higgins:
Sure. So, I treat the vast majority of my stage III patients with intensity-modulated radiation therapy, and with this technique, we’re able to reduce the radiation dose to the lungs as well as to the heart. We also used image-guided radiation therapy, and we’re able to use more advanced imaging each treatment day to make sure that the patient is lined up correctly. We can use smaller margins around the tumor to reduce the amount of lung that gets treated with radiation each day. And with these techniques, we’re able to give that full dose

of radiation for patients that have tumors that are distributed, let's say, on both sides of the mediastinum or even on both sides of the low neck.

Dr. Caudle:
Excellent, and thank you for sharing the ways in which you use radiation techniques to really develop customized treatment plans for your patients. You know, one consideration during chemoradiation therapy is that both chemotherapy and radiation can cause adverse events that really need to be managed, and you know this is really to ensure that patients are able to complete the full regimen, treatment regimen. So, how do you proactively, you know, manage these adverse events, and how does this help patients really go on to be able to complete their concurrent chemoradiation therapy?

Dr. Higgins:
Sure. So, one of the main toxicities that we'll see with concurrent chemoradiation is esophagitis, or inflammation of the esophagus. What I do at the outset of treatment is I start a patient on a PPI, and then each week I'm asking them about their swallowing. And, of course, we also use IV fluids, particularly in the last few weeks of treatment if a patient needs extra support. It's really imperative to try to manage down those side effects so that they can go on to get the immunotherapy. And also, maintaining good communication with a multidisciplinary team during that time is really critical.

Dr. Caudle:
Excellent. You know, I can see, especially with these adverse events, how communication with the patient in that setting is very, very important. Let's talk a little bit about communication between medical and radiation oncology teams, so let's talk about your best practices or some ideas that you use when communicating with a medical oncologist prior to a concurrent chemoradiation therapy during treatment and then following chemoradiation.

Dr. Higgins:
Sure. So, I think that's critically important. All of our stage III patients get presented at a multidisciplinary tumor board, so we get everybody's opinion on the best management at the outset and that we have a clear message that we communicate from both teams to the patient.

During treatment, we have touch points with our medical oncology team, typically at our multidisciplinary tumor boards, where we talk about our patients that are on treatment: "How are they doing?" "Are they having side effects?" "I started this patient on this medicine to help with esophagitis." "He's getting fluids," this or that, so that everybody is aware of how the patient is doing and what to look for and how we can be proactive and anticipate our patient's needs.

Dr. Caudle:
Right.

Dr. Higgins:
And then really, again, I want to make the point that those last 2 weeks of treatment are really critical to make sure that the patient is able to recover from the side effects and get the immunotherapy in a timely fashion.

Dr. Caudle:
Absolutely. These are really, really excellent points. And before we wrap up, Dr. Higgins, what takeaway thoughts would you like to share with other radiation oncologists on this topic of concurrent chemoradiation therapy for unresectable stage III non-small cell lung cancer in the curative intent setting?

Dr. Higgins:
Our radiation techniques are getting better, treatment is better tolerated. We have immunotherapy to add on after the chemoradiation.

Dr. Caudle:
That's excellent. Wonderful. Well, with those closing thoughts, I very much want to thank my guest, Dr. Kristin Higgins, for sharing her perspectives and best practices when treating patients with unresectable stage III non-small cell lung cancer.

Announcer:
This program was sponsored by AstraZeneca. If you missed any part of this discussion or to find others in this series, visit reach-m-d-dot-com-slash-navigating-NSCLC. This is ReachMD. Be part of the knowledge.

References

- Boyle J, Ackerson B, Gu L, et al. Dosimetric advantages of intensity modulated radiation therapy in locally advanced lung cancer. *Adv Radiat Oncol*. 2017;2(1):6-11.

- Brahmer JR, Govindan R, Anders RA, et al. The Society for Immunotherapy of Cancer consensus statement on immunotherapy for the treatment of non-small cell lung cancer (NSCLC). *J Immunother Cancer.* 2018;6(1):75.
- Chang JY, Dong L, Liu H, et al. Image-guided radiation therapy for non-small cell lung cancer. *J Tharac Oncol.* 2008;3(2):177-186.
- Cheema PK, Rothenstein J, Melosky B, et al. Perspectives on treatment advances for stage 111 locally advanced unresectable non-small-cell lung cancer. *Curr Oneal.* 2019;26(1):37-42.
- Kong M, Hong SE. Comparison of survival rates between 3D conformal radiotherapy and intensity-modulated radiotherapy in patients with stage lll non-small cell lung cancer. *Onco Targets Ther.* 2016;9:7227-7234.
- Phernambucq EC, Spolestra FO, Verbakel WR, et al. Outcomes of concurrent chemoradiotherapy in patients with stage lll non-small-cell lung cancer and significant comorbidity. *Ann Oncol.* 2011;22(1):132-138.
- Ramnath N, Dilling TJ, Harris LJ, et al. Treatment of stage lll non-small cell lung cancer: diagnosis and management of lung cancer, 3rd ed: American College of Chest Physicians evidence-based clinical practice guidelines. *Chest.* 2013;143(5 suppl):e314S-e340S.
- Verma V, Simone CB II, Werner-Wasik M. Acute and late toxicities of concurrent chemoradiotherapy for locally advanced non-small cell lung cancer. *Cancers (Basel).* 2017;9(9):e120.

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