

Transcript Details

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Multidisciplinary Perspectives on Managing Patients with Unresectable Stage III NSCLC

Announcer:

Welcome to ReachMD. This medical industry feature, titled "Multidisciplinary Perspectives on Managing Patients with Unresectable Stage III NSCLC" is sponsored by AstraZeneca. This program is intended for physicians. Here's your host, Dr. Jennifer Caudle.

Dr. Jennifer Caudle (host):

Coming to you from the ASTRO Annual Meeting in Chicago, Illinois, I am your host, Dr. Jennifer Caudle, for ReachMD. Our panel of experts today includes Dr. Alexander Whitley, a radiation oncologist at Central Alabama Radiation Oncology in Montgomery, Alabama, Dr. Alejandro Calvo, a medical oncologist at Kettering Cancer Care in Kettering, Ohio, and Kim Rohan, a nurse practitioner at Edward Hematology Oncology Group in Naperville, Illinois. Today we're going to focus our discussion on the treatment of unresectable stage III non-small cell lung cancer. We're going to discuss treatment in a curative intent setting and the role of the multidisciplinary team during guideline-recommended concurrent chemoradiation therapy as well as best practices based on our panel's experience.

Distinguished panel, thank all so much for being here today.

Ms. Kim Rohan:

Thank you.

Dr. Alexander Whitley:

Thank you.

Dr. Alejandro Calvo:

My pleasure.

Dr. Caudle:

Absolutely. Really excited to begin our discussion. So, Dr. Whitley, I'm going to start with you. And first of all, can you provide your perspective as a radiation oncologist on the treatment setting for unresectable stage III non-small cell lung cancer and really in particular the role of concurrent chemoradiotherapy as the standard of care in the patient population?

Dr. Whitley:

Yes, for stage III unresectable disease, combined-modality chemoradiotherapy has been established over 2 decades, 2½ decades,

as the standard of care for treatment, and we have studies with radiation alone and then chemotherapy followed by radiation, or vice versa, followed by combined-modality chemoradiotherapy that has been established for standard of care for curative intent unresectable disease.

Dr. Caudle:

Excellent. And how about you, Dr. Calvo? What's your perspective as a medical oncologist on curative intent concurrent chemoradiotherapy in this setting?

Dr. Calvo:

Yes, as Dr. Whitley said, it's been a work in progress for many years.

Dr. Caudle:

Sure.

Dr. Calvo:

We've been using different combinations and sequences, and I think in 2019 we have a standard of care which is the use of concurrent chemotherapy radiation followed by consolidated immunotherapy for patients who do not progress after initial part of the treatment.

Dr. Caudle:

Okay. Excellent. And what's your perspective on this topic, Ms. Rohan? What are your thoughts about this?

Ms. Rohan:

Well, I think it's an exciting time that we are actually talking about curative intent in unresectable disease, so I think that's very exciting, and it gives patients a lot of hope and their families a lot of hope, and it's exciting for us who have been caring for these patients over the last 30 years to really have this new multidisciplinary approach to the care of those patients with stage III unresectable lung cancer.

Dr. Caudle:

Right. Okay, excellent. You know, so now, I'm going to go back to each of you because I'd like us to talk briefly about each of your roles in patient management during concurrent chemoradiation therapy and really provide your perspective on how the multidisciplinary team can collaborate during the patient journey. So, Dr. Whitley, let's start with you again about that.

Dr. Whitley:

Right. So, there's been, I guess, a transition in at least our community of referral to both radiation oncology and medical oncology from the pulmonologist, which has been nice, because we know delays in start of therapy impact outcomes.

Dr. Caudle:

Right.

Dr. Whitley:

So, there is some coordination up front and then coordination from timing of combined-modality chemoradiotherapy at the same time given, start at the same week, so a lot of communication between medical oncology and radiation oncology to get going. And then I think there is a lot of communication about expected toxicities based on size of malignancy from a radiation standpoint as we've kind of modernized the radiation therapy for lung cancer with IMRT and decreased toxicities. We can treat more effectively.

Dr. Caudle:

Excellent. And, Dr. Calvo, what's your thoughts, especially about the multidisciplinary team and collaboration in this journey?

Dr. Calvo:

I think that's a very important concept for our patients. Sometimes that's a challenge when we're dealing in a community setting because we're not necessarily under the same roof, but fortunately, I think we communicate very well between the different

specialties to ensure that the patient starts on treatment in a timely manner. Sometimes we have to talk about what will be the best chemotherapy regimen because there are several options, and that's something I like to discuss with the radiation oncologist after looking at comorbidities.

Dr. Caudle:
Right.

Dr. Calvo:
So I think communication and multidisciplinary approach is key.

Dr. Caudle:
Right, right. Excellent. And, Ms. Rohan, what are your thoughts about this?

Ms. Rohan:
Well, I think as the nurse practitioner and the nurse navigator for our program is it's helping set the expectations for patients and really being that kind of cog in the wheel for the multidisciplinary team as the person that's really helping the patient navigate through their treatment journey and assisting them in making sure that they understand the treatment plan and the expected side effects that may occur from the treatments.

Dr. Caudle:
Excellent. So now let's talk a little bit more about communication. Dr. Calvo, I'm going to start with you on this one. How do you as a medical oncologist communicate with your radiation oncologist when developing a treatment plan for a patient with unresectable stage III non-small cell lung cancer?

Dr. Calvo:
This is very crucial to ensure a timely initiation of therapy in those patients, so I usually call them on the phone. I just don't go with the standard referral that goes through a computer system or paper system because that will take too many days. And I like to also discuss with them the chemotherapy part because I like to get the input of radiation oncology of what regimen they think is also more adequate for the patient depending on their performance status and comorbidities.

Dr. Caudle:
Sure.

Dr. Calvo:
So, communication is key for that.

Dr. Caudle:
Absolutely, absolutely. And so, Dr. Whitley, let's talk about you and how you communicate then with your medical oncologist when developing a treatment plan.

Dr. Whitley:
I think it's similar. Some of the cases obviously go through a multidisciplinary tumor board, so we're having the discussion there, but many of the cases, at least in our practice, probably don't, so it's personal phone calls back and forth to initiate therapy, deem them to be unresectable and kind of proceed from there, so I think it's integral from a communication standpoint, especially in our setting where we are private practice. Medical oncology is housed in a different place, so you know we have different electronic medical records, so communicating that way versus waiting for a note to be faxed or something along those lines is integral.

Dr. Caudle:
Right, right, communication certainly is key. And let's switch now to how we communicate with our patients. So, how do each of you—and we're going to go through each of you—how do each of you communicate your treatment plans to your patients and their families? Obviously, a very important thing here. Dr. Calvo, let's start with you about that.

Dr. Calvo:

Yes, I try to emphasize 2 concepts. The first one is that we are going on a curative intent, and it's very important to stay on schedule. I also tell them ahead of time that the treatment is going to have 2 chapters—the chemoradiation, and if they don't have progression, immunotherapy—so it doesn't become a surprise once they go through the first part of the journey.

Dr. Caudle:

Sure.

Dr. Calvo:

The second part of my conversation is related to toxicities, so they are educated as to recognize them early and addressing them early so we can maintain their performance status and avoid treatment delays.

Dr. Caudle:

Right, right, makes a lot of sense. Dr. Whitley, what's your approach?

Dr. Whitley:

I would echo the same thing. It's kind of laying the game plan out to start with of combined chemoradiotherapy followed by consolidated immunotherapy and what it takes to get there and maintaining performance status just like Dr. Calvo said.

Dr. Caudle:

Right. And, Ms. Rohan, talk to us about your role. Your role is really critical to ensuring that the patient understands how they're going to be treated, why, and also what to expect during treatment. What are your thoughts about how you proceed?

Ms. Rohan:

Yeah, I'm fortunate that we do have a multidisciplinary conference that meets every week, so the whole team is together at least on a weekly basis, so I think that helps with communication. Prior to the start of therapy, every patient is set up with a 1-hour consultation with me to talk about side effects, when to call us, what things to watch out for, how to manage common side effects, and then at the same time, I consent the patients for the therapy. So, I think it's important that patients understand that this is a treatment, that it's a combination of treatment that is going to be followed by another year of therapy, so laying down that expectation that how we're going to monitor them when they're done with their chemoradiation and ensuring that they and their families feel comfortable with the approach and understand the approach to their care.

Dr. Caudle:

Right, very, very good points as well. Now let's move a little bit to care coordination when it comes to adverse events. You know, if we consider the coordination needs for managing adverse events, how do each of you communicate with each other as a multidisciplinary team to manage these adverse events? Ms. Rohan, we're going to start with you again. What are your thoughts about this?

Ms. Rohan:

Well, in this day and age with cell phones, there is a lot of communication by phone or e-mail or texting, so I think that, you know, communication is crucial. Often times they are seeing the radiation team every day. A radiation therapist may go, "You know what? They don't look so good today," or, "Maybe they need their blood counts checked," and ensuring then that that patient gets the labs, gets whatever fluids or whatever medications that they may need, so it's integral that we're always communicating and have good communication algorithms for ensuring that we get a hold of each other and keep that patient getting the best treatments.

Dr. Caudle:

Sure, sure. Dr. Calvo, how about you? What are your thoughts?

Dr. Calvo:

Yes, there are some obstacles when we treat these patients—mucositis leading to dehydration, nutritional problems, infection—and I think if we recognize them early and address them early, it will give those patients performance status in a level where they can

continue with therapy, avoid treatment interruption. And I think communication is important because sometimes we run the risk of duplicating efforts or also the opposite where somebody thinks that the other team is going to take care of the problem, so like Ms. Rohan said, it's very important to communicate. They see radiation oncology more often than they see medical oncology, but we can all put our heads together to help them the best we can.

Dr. Caudle:

Right, also very good points. And finally, Dr. Whitley, what are your thoughts about this?

Dr. Whitley:

Well, from a side effect management, with radiation treatment plans we can often times predict the types of side effects that patients are going to get, so informing them kind of up front what they might expect, and be aggressive about management, and then communicating that to our medical oncologists so they're aware that this patient might have issues with dehydration because of esophagitis or something along those lines. And at least in our center, you know, it's 2 different facilities, so getting them for IV fluids, often times it's good communication with the nurse practitioners next door to make things happen kind of expeditiously so patients don't have delays in therapy.

Dr. Caudle:

Right, excellent. You know, to wrap the conversation up, you know, I'd really like to go back to each of you to talk about any takeaways that each of you would like to share with other specialists on concurrent chemoradiotherapy for unresectable stage III non-small cell lung cancer in the curative intent setting. So, what takeaways, Dr. Calvo, we'll start with you. Let's start with any takeaways you might have.

Dr. Calvo:

I think the most important takeaway is that we treat those patients with a curative intent approach, that the treatment is multidisciplinary and will include a combination of chemotherapy and radiation. So, my message for those practitioners would be to not be so nihilistic, refer the patient to radiation oncology, medical oncology, and the earlier we can see the patients the better.

Dr. Caudle:

The better, right. Dr. Whitley, what are your thoughts?

Dr. Whitley:

I would echo the same thing, that sometimes there is a nihilism in the community setting if you've got advanced—locally advanced unresectable lung cancer that they'll go on to hospice and miss the opportunity to hear the discussion, so I would just echo what Dr. Calvo said, that referral so they can have an appropriate informed discussion.

Dr. Caudle:

Right, that makes a lot of sense. And last but certainly not least, Ms. Rohan, what are your thoughts? What are your final words?

Ms. Rohan:

I think it's very exciting for those of us who have cared for lung cancer patients for a long period of time to be talking about curative intent, and it's exciting for patients and families, or at least soothing to their angst that we're really working at it. This is a multidisciplinary approach for a curative intent for their cancer and that we're making strides every day and we're continuing to move that forward, so I think it's very exciting for those of us in the field but also for patients and families.

Dr. Caudle:

Absolutely agree. These are all excellent points for us to keep in mind when approaching the curative intent treatment in patients with unresectable stage III non-small cell lung cancer as a team. I'd really like to thank my panelists and specialists for sharing your thoughts. It was wonderful speaking with you guys today. Thank you so much.

Ms. Rohan:

Thank you.

Dr. Whitley:
Thank you.

Dr. Calvo:
Thank you.

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.

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