

# Challenges of Treating Elderly/Frail Patients with Lung Cancer, Part 1:

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## Considerations for Adjuvant Therapy



Dr. Paul J. Hesketh  
Medical Oncologist  
Director, Thoracic Oncology  
Lahey Clinic Medical Center  
Burlington, MA



Dr. Karen Kelly  
Medical Oncologist  
University of Kansas Medical Center  
Kansas City, KS



with Howard (Jack) West, MD  
Medical Oncologist  
President & CEO  
GRACE

## Declared Conflicts of Interest

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### Dr. Paul J. Hesketh

Research Funding – Eli Lilly

### Dr. Karen Kelly

Consultant – Eli Lilly, Bristol-Myers Squibb, Genentech

### Dr. Howard West

Consultant – Eli Lilly, Bristol-Myers Squibb

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We deeply appreciate their support.

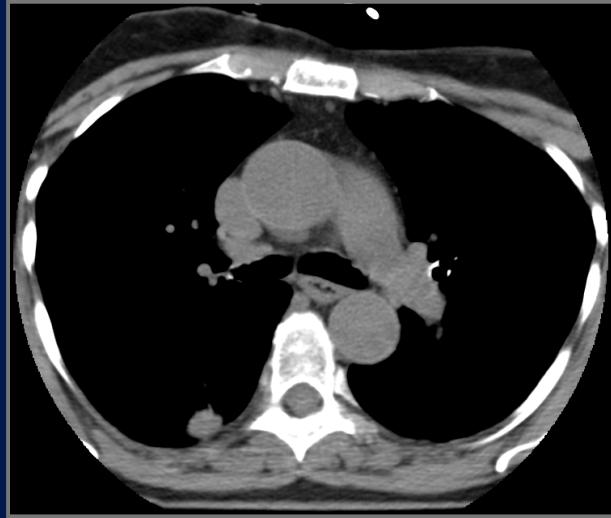
### Case 1: Resected stage II NSCLC

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- 77 year-old woman referred for consideration of adjuvant therapy after resection of T2N1Mx NSCLC
- Never-smoker, history of hypothyroidism, PAF: right chest discomfort, presented to outside ER: CT angiogram to r/o pulmonary embolus
- 1.6 cm pleural-based lesion in superior segment right lower lobe (RLL).
- Referred to pulmonologist, did not see for a few months. Repeat CT shows nodule now 2.0 cm
- PET/CT: hypermetabolism max SUV 7.6, no other areas of uptake
- Pulm function tests: FEV1 2.0 L, DLCO 88% predicted

## CT of Lesion

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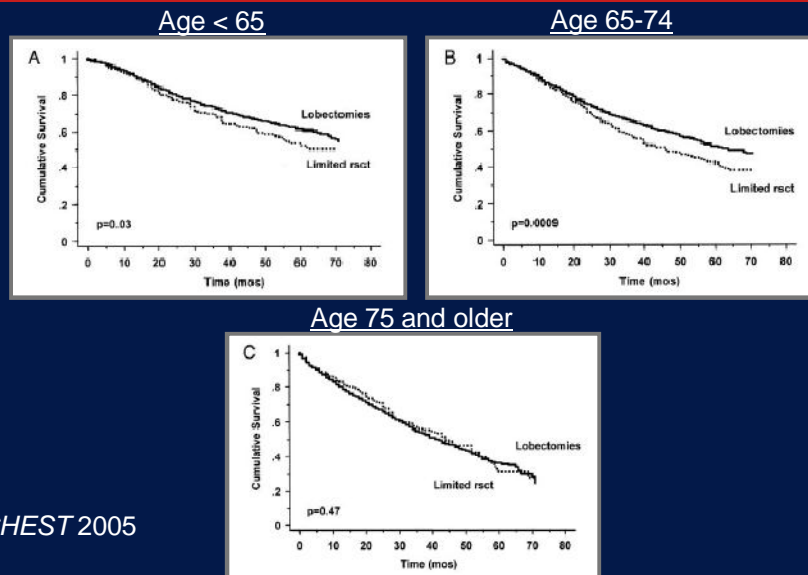


## Case 1: Referred to Thoracic Surgery

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- Underwent wedge resection for diagnosis, followed by completion lobectomy
  - Should she have had biopsy first, or is this high enough probability/wedge too straightforward?
  - Did she need completion lobectomy (data suggest older patients have equivalent survival for wedge vs. lobectomy)?
- Pathology
  - 1.8 cm adenocarcinoma, mixed acinar/BAC types
  - Moderately differentiated overall
  - Rare focus of tumor involving visceral pleura (T2)
  - One of 10 nodes with metastatic adenocarcinoma (0.4 cm)

## Limited Resection vs. Lobectomy, by Age



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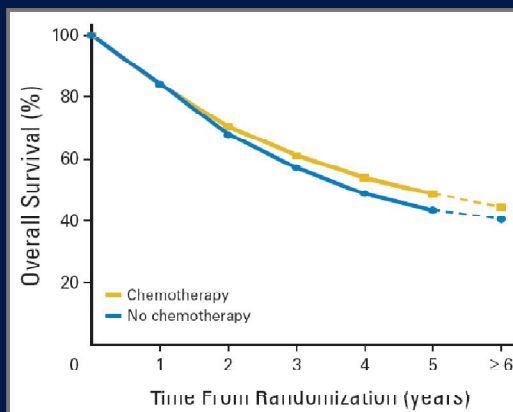
- Microscopically node-positive disease

Would you recommend adjuvant therapy?

- Standard chemotherapy?
- Consideration of EGFR-based therapy?

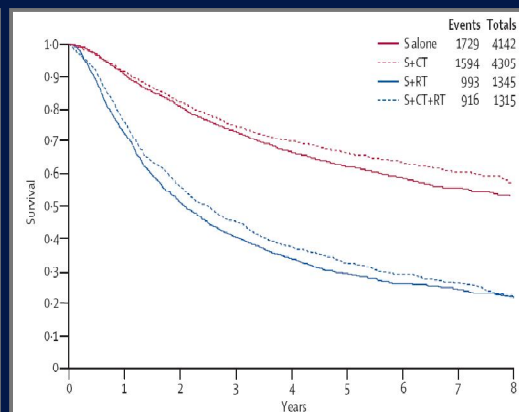
## Meta-Analyses Demonstrate Survival Benefit of Adjuvant Chemotherapy

LACE Meta-Analysis



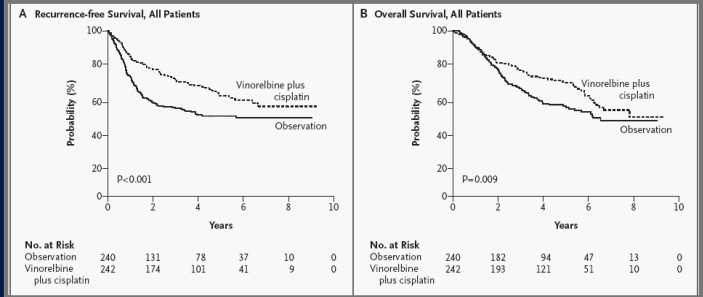
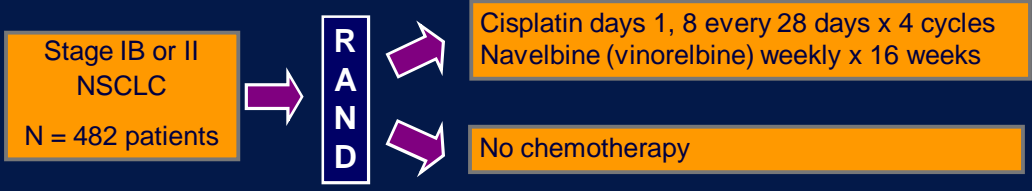
Pignon, *J Clin Oncol* 2008

NSCLC Meta-Analysis Collaborative Group



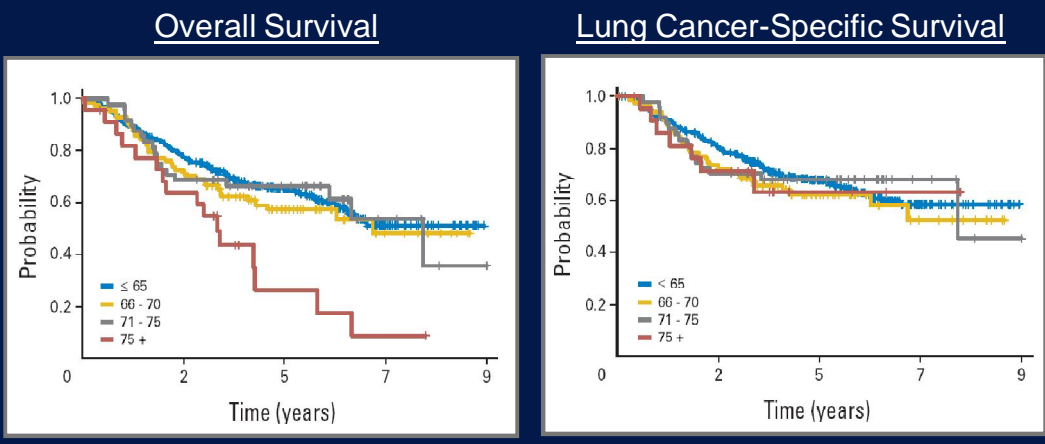
NSCLC Meta-Analyses Collaborative Group, *Lancet* 2010

# JBR.10 - Study Design



Winton, *N Engl J Med* 2005

# JBR.10 Trial of Adjuvant Chemotherapy: Survival and Lung Cancer-Specific Survival by Age



Pepe, *J Clin Oncol* 2007

## JBR.10: Differences in Drug Delivery for Adjuvant Chemotherapy, by Age

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- Patients > 65 received significantly less chemo
  - Navelbine (vinorelbine)
    - 71% of older patients receive <10 doses (vs. 50% for younger)
  - Cisplatin
    - 49% of older patients receive < 5 doses (vs. 27% of younger)
  - No significant differences in toxicity, or need for growth factor support
  - More elderly patients refused treatment

Pepe, *J Clin Oncol* 2007

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How do you decide on the chemotherapy to recommend for a patient with marginal kidney function?

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How do you prioritize platinum-based treatments for patients with good organ function and performance status but who are very concerned about chemo-related side effects after surgery?

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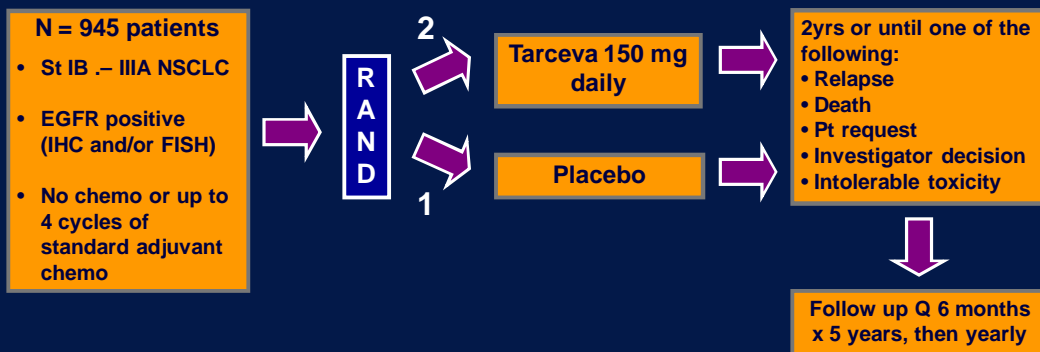
What is your approach to adjuvant chemotherapy for frail patients, regardless of age?

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Would you be inclined to send off tissue for molecular testing for EGFR and potentially use that information to recommend EGFR-based treatment?

## Randomized Double-Blind Trial In Adjuvant NSCLC with Erlotinib (RADIANT)

Principal Investigator – Dr. Karen Kelly



**Abstract ID: 7523**  
**Adjuvant gefitinib or erlotinib in patients with  
resected lung adenocarcinomas  
that harbor  
Epidermal Growth Factor Receptor (EGFR)  
mutations**

YY Janjigian, MG Kris, J Zheng, VA Miller, GJ Riely,  
R Shen, J Dycoco, B Park, CG Azzoli

Memorial Sloan-Kettering Cancer Center, New York, NY  
10065



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Would you send for ERCC-1 or any other  
“chemotherapy sensitivity testing” to help  
with making recommendations?

- In a very equivocal case for chemotherapy?
- In many/most patients who would be candidates for adjuvant therapy?

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