

Current Concepts & Controversies in Locally Advanced NSCLC, Case 3:

Bulky Unresectable Stage IIIB NSCLC and the Outer Limits of Curable Intent



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Conflicts of Interest

Dr. George Blumenschein

No significant conflicts of interest to declare.

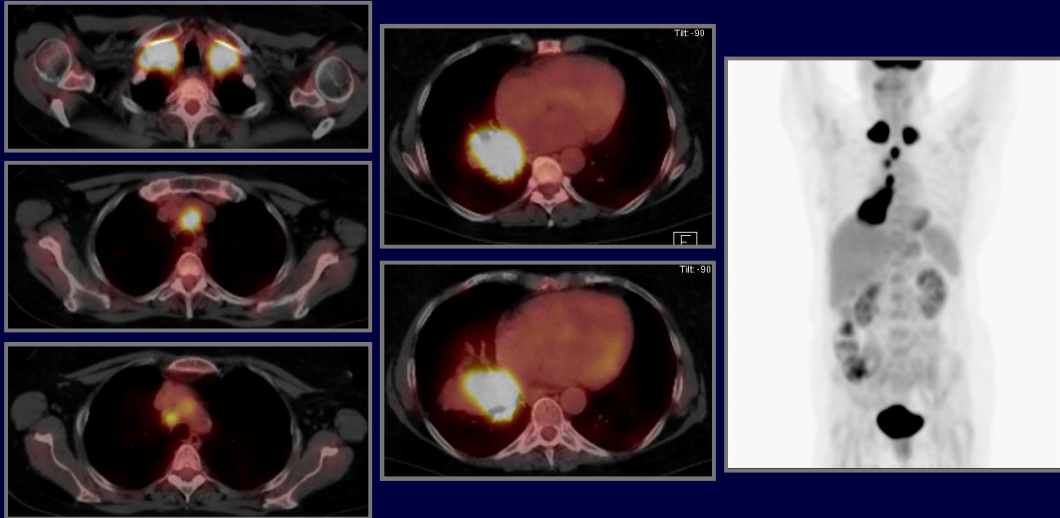
Dr. Walter J. Curran

No significant conflicts of interest to declare.

Stage IIB Unresectable NSCLC: Background

- 68 year-old prior smoker undergoing workup for nonspecific GI symptoms that included CT of abdomen & pelvis
- Large lobular RLL mass seen incidentally
- Chest CT → 6 x 6.5 x 4.1 cm mass centrally in RLL and extending into R hilum
- Mediastinal node enlargement up to 1.4 cm bilaterally, esp superiorly, and bulky supra-clavicular nodes bilat, up to 2.6 cm on L (>R).

PET Imaging



Stage IIIB Unresectable NSCLC: Additional Workup

- PET scan confirms max SUV 17.2 in primary RLL mass, extensive PET avidity throughout bilateral mediastinum, and uptake in bulky supraclavicular nodal disease bilat (max SUV 19 on R, 12.8 on L)
 - No evidence of distant metastatic disease
- Bronch w/biopsies: non-diagnostic
- Excision biopsy supraclav LN on L: moderately differentiated squamous cell carcinoma
- Head MRI: no evidence for intracranial metastases

Stage IIB Unresectable NSCLC: Further Background

- Past Medical History:
 - COPD, FEV1 1.3L
 - Anxiety disorder
 - Benign essential tremor
- Widowed, with daughter living nearby
- Perf status 1 (wheezing, dyspnea on exertion)
- Inclined to pursue aggressive therapy

Is it feasible to treat patients with cancer above the collarbone on the side opposite the main tumor (contralateral supraclavicular disease, N3 nodes) with curative intent?

Is it possible to cover this extent of disease safely with radiation?

If the extent of the cancer shrinks significantly after initial chemotherapy, do you favor radiating the residual disease, or some/all of the original extent of the cancer?

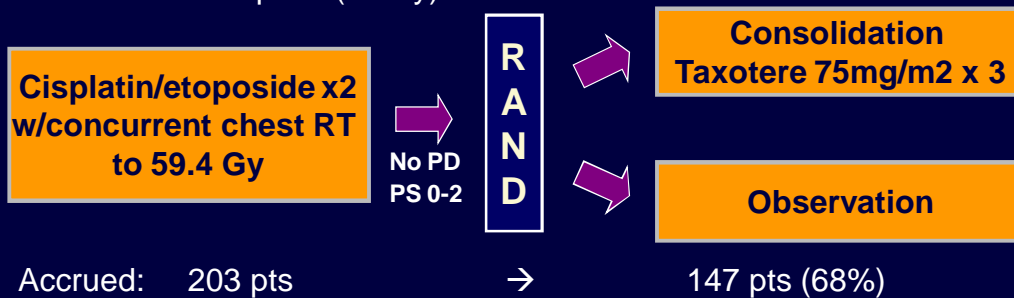
Treatment Administered

- She receives 2 cycles of cisplatin/etoposide with concurrent radiation to 64 Gy, which she tolerates with a lot of difficulty
 - Hospitalized for fluids/failure to thrive at end of Rx
 - Performance status declines to 2 range
 - No treatment delays with radiation
- PET/CT 4 weeks after Rx ends shows improvement but residual masses in RLL, supraclav regions, max SUV ~ 4-5 range

Would you be inclined to recommend additional chemotherapy in the setting of residual ambiguous imaging findings after chemo/radiation?

Hoosier Oncology Group (HOG) Trial: Direct Test of Consolidation Taxotere

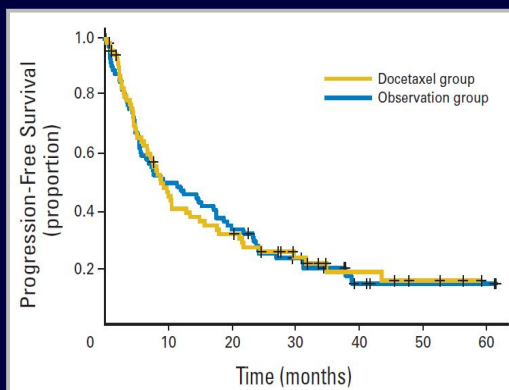
- Unresectable stage III NSCLC; FEV1 \geq 1.0L
- Primary Endpoint: Improvement in median survival, 15 \rightarrow 25 months
- Trial stopped early due to DSMB recommendation at planned interim time point (futility)



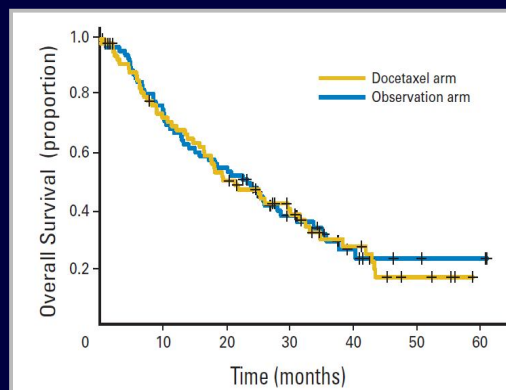
Hanna, *J Clin Oncol* 2008

HOG Trial: Direct Test of Consolidation Docetaxel

Progression-Free Survival



Overall Survival



Hanna, *J Clin Oncol* 2008

How can we address the ambiguity
of assessing the outcome of
chemo/radiation?

What is your practice pattern for
monitoring patients after
chemo/radiation?

When should we most typically
expect to see radiation pneumonitis
(inflammation of the lung tissue in
the radiation field)?

If a patient has interval scans to assess ongoing response to chemo/radiation during the radiation course and shows significant tumor shrinkage, do you change fields to concentrate on the new, smaller area or stay with original fields?

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