GCVL_LU-AA02:
Myths and Misconceptions About Bronchioloalveolar Carcinoma (BAC)

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TRANSCRIPT & FIGURES
One of the unusual subtypes of lung cancer is known as bronchioloalveolar carcinoma of the lung, or BAC. This is a rare type of cancer, about 2, 3, 4%, but it has its own lore about it and with that comes some misinformation and myths about managing BAC that I sometimes see causing some bad treatment decisions. I wanted to discuss some of those, as someone who has focused on BAC as a major concept in my own research over the last several years.

The first myth to address is that it is always slow growing or sometimes it may always be considered fast growing. In fact, there's a lot of variability in how BAC behaves. Sometimes it can be the slowest growing cancer you will ever see; even when it does grow, it might grow by a millimeter or two as a single nodule every year or two.

On the other hand, it is not always an indolent or slow-growing process and you can sometimes see it lead to increasing symptoms over a course of just weeks. So, each case needs to be individually assessed and you need to see how a patient is feeling over time, how their imaging is changing over time, and treat each case individually based on what you observe.

Another myth that we sometimes see is that BAC does not respond to standard chemotherapy. One of the challenges is that BAC tends to appear on scans not as a discreet measurable spot, some solid lesion in the lungs that you can readily measure the size of as it grows or shrinks, but rather as a hazy area that might be one spot; it might be multiple nodules that are all hazy, or it might be a diffused cloudy area. But that haziness is not readily measurable – it’s kind of like trying to measure how cloudy it is one day to the next if it’s just kind of diffusely gray outside.

The problem is that measuring tumor shrinkage is how we historically graded how chemotherapy works, and if you can't measure it shrinking, we've sometimes just categorically said "treatment doesn't work." However, when you look carefully at some studies that have given the same treatment to patients whether they have BAC or another form of lung cancer, particularly
an adenocarcinoma, which BAC is a subtype of, you really tend to see that it responds comparably to other forms of lung cancer to the same chemotherapy. So it is really a bit of misinformation that chemotherapy does not work for BAC.

Another myth that has emerged is that EGFR inhibitors such as Iressa (gefitinib) or Tarceva (erlotinib) are the treatment of choice for BAC. Now, this myth emerged because many of the patients who have responded extremely well to these oral EGFR inhibitors have BAC, and because of that it's been presumed that it is the treatment of choice. In fact, what we've seen is that patients who have an EGFR mutation are the very ones who will most likely benefit from EGFR inhibitors, and many patients with BAC will have one of these EGFR mutations, but certainly not all, and if patients don't have one of these mutations they tend not to do that well with these agents. So, an EGFR inhibitor is not necessarily the treatment of choice.

Another issue that comes up is that if surgery could be done, it should be done. That might even apply if patents have three of four different spots. What we sometimes see is that patients may want to have surgery because you want to get it out, and many surgeons are inclined to oblige if they feel they can safely do that surgery – but it's not always a good idea. If there is one spot of cancer, taking it out is almost always a great idea as long as a patient can tolerate it. On the other hand, if there are 3 or 4 or 6 spots, even if it's possible to get them all out, it's not likely that that's all the cancer that is or will ever be. When you see multiple spots that usually means that, in addition, there are other spots likely to emerge over time just like if you take out a bunch of dandelions from your lawn, if your lawn has multiple dandelions, you can't pull them out and expect that's the end of that and you'll never see them again. In addition to the visible disease, there's invisible disease. There are little seeds, and there's likely to be additional cancers that pop up, and at some point many patients miss the lung that got removed for the surgery when there are new BAC lesions a few years later.
And the fifth myth that I'd like to address is the idea that treatment should be started immediately or promptly. Now, I mentioned that the pace of BAC is quite variable: sometimes it's extremely slow, sometimes it's quite aggressive. In patients who have a very slow process, they can do very well and often have no symptoms for years on end. There are even patients who might never be affected and have their life limited by the cancer, even if it's growing. If it's growing by a few millimeters at a time it does not necessarily need treatment and patients might do well for 5 or 10 years or more.

So, there's no clear incentive to starting a treatment like chemotherapy or even a pill-based therapy like an EGFR inhibitor, that has side effects associated with it and that works typically for a limited amount of time, if this is a problem that you're going to be managing over a very chronic basis. You just don't want to exhaust your treatments long before they are needed. So one strong idea is if a patient has a minimal amount of cancer that's growing slowly and they don't have symptoms, it makes good sense to think about holding off on treatment until there's a clear need to intervene.
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