2022 Case Based Panel Discussion

Treating Stage III NSCLC

Speakers:

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TRANSCRIPT

Dr. Dagogo-Jack: And so I guess for for you, Kathryn, when you meet a patient, if this person is coming to your clinic at this point with a stage three lung cancer, are there any additional studies that you tend to order to help guide your treatments? And what are you thinking as far as treatment?

Dr. Arbour: I think the management of stage three lung cancer is sometimes institution dependent, and it depends on what the practice policy of your hospital is, what the perspective of a multidisciplinary team. But this is really an aspect in which multiple different services can come together to together to find out how best to manage a patient's lung cancer. For a particular patient, that might mean radiation. For a particular patient, that might mean surgery, that might mean systemic therapies, which US medical oncologist give, and to guide that choice of systemic therapy, I find that molecular testing, at least to identify the most common alterations, is frequently helpful and that molecular testing includes, for me, both Pd-l1 testing to get a sense of how likely immunotherapy may be additionally beneficial for a patient, as well as testing to identify common driver oncogenes or mutations in lung cancer, such as EGFR mutations or ALK rearrangements that may make someone less likely to respond to immunotherapy but may identify someone for clinical trials in this space.

So these this is the type of testing, if it can be done efficiently and pretty rapidly, that can be done in parallel with the rest of these consultations.

Dr. Dagogo-Jack: Yeah. And sometimes we hear words like next generation sequencing or single gene test. In your practice, do you tend to do next generation sequencing and what is that? Why is how is that different than just looking for EGFR?

Dr. Arbour: So next generation sequencing is, you know, a fancy term, but really means kind of looking at multiple different alterations in practice. So not doing single gene testing. The problem and the challenge of single gene testing is if you use up a piece of the biopsy for one gene and then another piece of a biopsy for another gene and another gene, you can run out of biopsy material and still not get a comprehensive answer. Next generation sequencing may encompass a panel of over 500 genes, may encompass a panel of the more common 80 genes that we look at, or even smaller than that.

But really, we're looking for the more common alterations in non-small cell lung cancer that have what we call actionable mutations, mutations that we may have a targeted therapy involved for. And I would argue in the metastatic setting, the timing is important, but sometimes we can wait for this in this setting of early stage disease. We really want to get to that answer relatively quickly and pretty small panels can can get to that answer fairly efficiently and really I think should be considered standard of care for all patients and are generally covered by insurance as well.

And so we encourage that that testing to be performed.

Dr. Dagogo-Jack: Yeah. So think that you're exactly right. So it's always a tension, right, between getting all the information we need and getting it as quickly as possible, especially in this setting, which I will point out for stage three lung cancer, The treatments that we're giving are intent is to cure you of the cancer in this setting.