CASE BASED PANEL DISCUSSION: LUNG CANCER

Non-Bulky NSCLC 2B Disease: The Role of Chemoimmunotherapy

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TRANSCRIPT

Dr. Ana Velazquez Manana: Our fourth case is a 53-year-old woman with a remote smoking history who presents with a right middle lobe poorly differentiated non-small cell lung cancer, involving non-bulky, small volume, mediastinal-node disease on both sides 4R and 4L, no driver mutations, and the PD-L1 is 50%. A surgeon who has guided her workup says he thinks this is all potentially resectable and he is especially optimistic of a good outcome if she has a good response to neoadjuvant chemoimmunotherapy. You are discussing options in your multidisciplinary tumor board. And the surgeon states that the patient is very excited about the possibility of a pathologic complete response. So, for this patient, who has Stage IIIB disease with bilateral 4R and 4L involvement, would you favor preoperative chemoimmunotherapy followed by surgery, non-surgical management with chemoradiation followed by immunotherapy, or perhaps some other approach.

Dr. Stephen Liu: This is tough. I can share our own institution's experience and would love to hear both of yours. But generally, for contralateral mediastinal nodal involvement, we are not favoring a surgical approach to us, that is a case that we would direct towards definitive chemoradiation, followed by immunotherapy consolidation.

Dr. Justin Gainor: I completely agree. I think that while, yes, chemoimmunotherapy is the new conversation piece in multidisciplinary tumor boards, I think we can't forget the first principles. And first principles are contralateral mediastinal lymph node involvement is a contraindication to surgery. So, I think this would be a case where I would reinforce that, yes, PD-1 pathway blockade is going to be a component of therapy, but the standard of care here would be definitive chemoradiation followed by durvalumab.

Dr. Justin Gainor: We don't really view chemo IO as conversion therapy. We do radiographic imaging, tends to underestimate the degree of pathologic response. So, I think for all of those reasons, I would not be enthusiastic about a surgical approach.

Dr. Ana Velazquez Manana: I definitely agree. This is the patient that we would send to CR folks in radiation and discuss a curative intent chemoradiation approach. And I think with all the upcoming and developing data in the immediate neoadjuvant space, one of my worries is are we going to start over-treating patients, or you could wonder if under-treating at the same time, by trying to downstage them with giving neoadjuvant therapy and making them resectable. Patients within **[03:30 inaudible]** and bilateral mediastinal involvement were not included in any of the trials that we've been discussing with IMpower010 or CheckMate 816. So, definitely, this would not be a patient that I would recommend for surgical resection either.

Dr. Stephen Liu: I agree, but I will say that I would have the equipoise to study in that setting. And I think that our outcomes for 3B with chemorad, I think there can be some improvement and neoadjuvant chemoimmunotherapy, the outcomes have been quite impressive. So, I think that a direct randomized trial of neoadjuvant versus adjuvant will be difficult to do. And a randomized study of chemoimmunotherapy for resectable versus chemorad it's also very difficult to do. But for 3B, maybe there will be enough volume to do a trial **[04:22 inaudible]** setting. You need to do very specialized centers. Because the surgery there, if you're doing a bilateral note of the section, that's going to require a sternal thoracotomy to get full bilateral mediastinal node coverage, and it's very tricky. So, I think that there's a potential to do a trial in that space, but I think I'll study. It sounds like we're in agreement.

Dr. Ana Velazquez Manana: And I think the other part to add here is **[04:51 inaudible]** driver mutations. What does that mean? And I think across centers and across the United States, particularly with community settings, there's a lot of viability on what testing we are obtaining. So, something to consider here, too, before giving or committing to chemoradiation followed by a year of immunotherapy is what's truly complete molecular testing of the tumor done, and should immunotherapy **[05:19 inaudible]** if they continue to be a component here or not, or hold it off?