CASE BASED PANEL DISCUSSION: LUNG CANCER

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

Dr. Stephen Liu (Assoc. Professor of Medicine, Georgetown, Director of Thoracic Oncology, Head of Dev. Therapeutics, Georgetown Lombardi Comp. Cancer Center)

Dr. Ana Velazquez Manana (Medical Oncology Fellow, UCSF Helen Diller Family Comprehensive Cancer Center)

Dr. Justin Gainor (Director. Center for Thoracic Cancers, Director of Targeted Immunotherapy, Professor of Medicine, Harvard Medical School)

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?