

Treatment of Locally Advanced Non–Small Cell Lung Cancer



Kit Tam, MD^a, Megan Daly, MD^b, Karen Kelly, MD^{a,*}

KEYWORDS

• Non–small cell lung cancer • Chemoradiation • Locally advanced disease

KEY POINTS

- Stage III non–small cell lung cancer (NSCLC) is a heterogeneous disease.
- Concurrent chemoradiation with platinum/etoposide and carboplatin/paclitaxel is the standard of care for unresectable disease.
- 60 Gy in standard fractionation remains the standard of care for radiation dose.
- Integration of novel immunotherapeutic and molecular targeted therapies is a promising area of investigation.

INTRODUCTION

Stage III NSCLC comprises the most heterogeneous group of patients and accounts for one-third of all patients diagnosed with lung cancer. Despite this heterogeneity, chemoradiation is the treatment of choice for the majority of patients. The 2-year and 5-year overall survival (OS) rates are estimated at 55% and 36%, respectively, for patients with stage IIIA disease and 34% and 19%, respectively, for patients with stage IIIB disease.¹

PATIENT EVALUATION

To accurately classify a patient within this diverse stage, a comprehensive work-up is imperative. After a thorough history and physical examination, staging focuses on the pathologic and radiographic assessment of primary and/or nodal disease and assessment of a patient's physiologic reserve and expected tolerance to planned therapies.

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^a University of California Davis Medical Center, 4501 X Street, Suite 3016, Sacramento, CA 95817, USA; ^b University of California Davis Medical Center, 4501 X Street, Suite G-140, Sacramento, CA 95817, USA

* Corresponding author.

E-mail address: karkelly@ucdavis.edu

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Initial imaging includes a computerized tomography (CT) of the chest to delineate local and regional disease and anatomic relationship to normal thoracic structures, whole-body positron emission tomography (PET)/CT for regional and distant staging, and a brain magnetic resonance imaging (MRI) to evaluate for intracranial metastases. Pathologic disease confirmation should be obtained from the most accessible tumor site, whether primary or nodal. Primary tumors may be accessed by CT-guided fine-needle aspiration or core biopsy, surgically via video-assisted thoracoscopic surgery, or by endobronchial ultrasound-guided fine-needle aspiration for centrally located tumors adjacent to bronchus. Nodal deposits may be accessed via endobronchial ultrasound (levels 2R/2L, 4R/4L, 7, and 10R/10L), esophageal ultrasound (levels 5, 7, 8, and 9), mediastinoscopy, mediastinotomy, or video-assisted thoracoscopic surgery.

If surgical management is being considered, comprehensive pathologic mediastinal staging is recommended (Fig. 1) especially because the rates of both false-positive and false-negative PET/CT interpretations for mediastinal nodes remain high. A meta-analysis of 28 studies, including 3255 patients, identified sensitivity and specificity of 0.67 and 0.87, respectively, for PET/CT in the nodal staging of NSCLC.² Patients with bulky, multistation mediastinal adenopathy less commonly undergo comprehensive pathologic nodal staging and are managed nonsurgically. Biopsy of

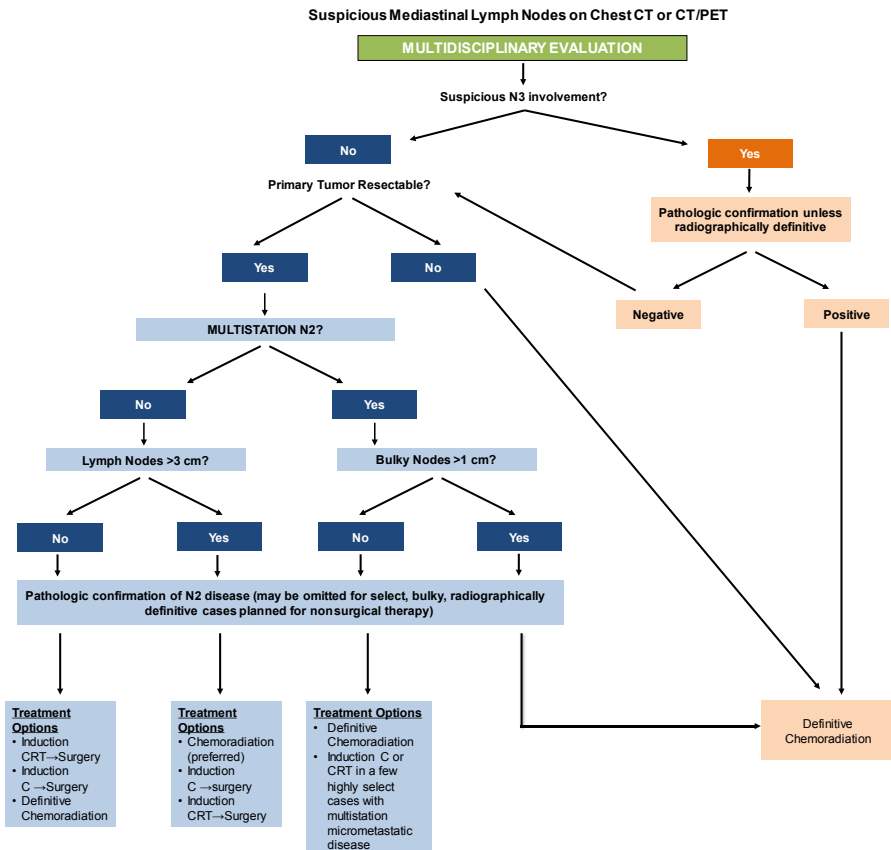


Fig. 1. Recommended evaluation and treatment strategy for patients with radiographically suspicious mediastinal nodes. C, chemotherapy; CRT, chemoradiotherapy.

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