CONCLUSIONS AND TAKE HOME MESSAGES

Martin Reck
Department of Thoracic Oncology
LungenClinic Grosshansdorf
A LOT OF INFORMATION CAN BE FOUND BY ESMO PUBLICATIONS


• 2nd ESMO Consensus Conference on Lung Cancer: Pathology and molecular biomarkers for non-small-cell lung cancer. (Kerr K et al, Ann Oncol 2014)

• 2nd ESMO Consensus Conference on Lung Cancer: non-small-cell lung cancer first-line/second and further lines of treatment in advanced disease (Besse B et al, Ann Oncol 2014)

• 2nd ESMO Consensus Conference in Lung Cancer: locally advanced stage III non-small-cell lung cancer (Eberhardt WE et al, Ann Oncol 2015)

• Metastatic Non-Small-cell lung cancer (NSCLC): ESMO Clinical Practice Guidelines for diagnosis, treatment and follow up (Reck M et al, Ann Oncol 2014)
RESECTABLE NSCLC

- Appropriate histological diagnosis of the tumor should be performed with limited use of defined IHS markers
- In case of adenocarcinoma the new classification system of adenocarcinoma should be applied
- Besides cardiopulmonary staging adequate mediastinal staging implementing new endoscopic methods like EBUS/EUS is recommended
- Surgery and systemic mediastinal lymph node resection remains standard treatment in resectable early stage NSCLC
- In unfit patients stereotactic radiotherapy represents an efficacious new option
- Adjuvant chemotherapy should be offered to patients with stage II and IIIa disease and may be offered to patients with IB disease and a primary tumor > 4 cm.
- Neoadjuvant chemotherapy improves OS and DFS
- The role of induction CT/RT remains to determined.
LOCALLY ADVANCED NSCLC

• In patients with IIla/IIlb (multilevel N2/bulky disease) concurrent chemoradiotherapy remains standard of care
• In patients with resectable IIla (single node N2) disease multimodal treatment including surgery may be considered on a patient based decision in centres with great experience
METASTATIC NSCLC DIAGNOSIS

• Adoption of the new classification of Adenocarcinoma strongly recommended
• Use of predictive immunohistochemistry to reduce the frequency of NOS < 10%
• Systematic EGFR mutation testing recommended in nonsquamous NSCLC. Test methodology should have adequate coverage of relevant mutations.
• Testing for ALK rearrangement should be carried out in advanced NSCLC with a non-squamous histology.
• FISH remains the standard but IHC may have a role in screening out negative cases
• If possible, parallel testing for molecular aberrations is preferable.
• Re-biopsy at progression should be considered
• Pemetrexed preferred to Gemcitabine in non-squamous NSCLC (II,B)
• Bevacizumab may be offered to eligible patients with non-squamous NSCLC (I,A)
• In PS =/> 2 patients Platinum-based combinations may be considered as an alternative to monotherapy (II,B)
• Platinum based chemotherapy preferred option for elderly patients (PS 0-1) and selected PS 2 (I,B)
• First-line TKI should be prescribed to patients with tumors bearing an activating EGFR-mutation (I,A)
• Patients harboring an ALK rearrangement should be offered treatment with crizotinib during the course of their disease (I,A)
METASTATIC NSCLC
TREATMENT II

• In patients with CNS metastasis systemic therapy is a reasonable option for patients with no/minor symptoms and with early radiotherapy intervention in case of progression (II,B)
• In non-squamous NSCLC improvement of PFS and OS with switch maintenance with pemetrexed
• In all histologies improvement of PFS and OS by switch maintenance with erlotinib with greatest benefit in patients with stable disease
• Continuation therapy with pemetrexed following completion of first-line cisplatin/pemetrexed is recommended (I,B)
• Second-line treatment: Erlotinib is an additional option in patients with unknown EGFR status or EGFR WT status.
• Close follow-up (every 6 weeks) is advised (III,B)
COME AND STAY!
YOU WON´T REGRET IT!

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