ESMO – ASCO – NCCN: Common ground and differences – which one to follow ?

Early and locally-advanced non-small-cell lung cancer

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Conflict of interest statement- WEE Eberhardt

1. CEO function or other direct job relationships

none

2. Advisor function

advisory board function	Astra Zeneca, Roche, Eli Lilly, Novartis, Pfizer, BayerSchering, Sanofiaventis, Boehringer Ingelheim, BMS, GSK, Amgen, MerckSerono

3. stocks

none

4. honoraria

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5. research funding

none

6. scientific evidence

none

7. other financial relations

none

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Lung cancer clinical practice guidelines

International Lung Cancer Guidelines

ESMO	ASCO	NCCN
2013 regular updates	I. 2007 II. 2003/2009	2014 yearly updates
Evidence-based Expert steering group Larger Expert panel	**Evidence based Expert Panel**	**Evidence based Expert panel**
for all recommendations referrences are given Evidence criteria given	for all recommendations referrences are given No evidence criteria	not for all recommendations referrences are available, very broad evidence criteria

International Lung Cancer Guidelines

early stages I and II

I. Surgery in early disease I and II

ESMO	ASCO	NCCN
aim is R0	aim is R0	aim is R0
standard lobectomy treatment of choice VATS possible	NA	organ sparing surgery is principle aim VATS possible
mediastinal lymph node dissection based on IASLC criteria	NA	systematic lymph node dissection or sampling

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II. Radiotherapy in early disease I and II

ESMO	ASCO	NCCN
stage I < 5 cm	NA	stage IA
SABR is recommended if unfit for surgery BED > 100 Gy	**NA**	SABR or definitive RTx if medically not fit for sugery
stage I > 5 cm or central location or stage II qd RTx	**NA**	stage IB or II definitive RTx adjuvant CTx to be considered

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III. Indication of adjuvant chemotherapy

ESMO	ASCO	NCCN
II,III routinely	**II,III routinely**	**II,III routinely**
IB > 4 cm or > 5 cm possible	**IB not recommended for routine use**	**IB risk factors** Undifferentiated, partial neuroendocrine, vascular invasion, > 4 cm, pleural invasion, no lymphadenectomy
IA not recommended	**IA not recommended**	**IA not recommended**

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IV. Performance of adjuvant chemotherapy

ESMO	ASCO	NCCN
Cisplatin-based	Cisplatin-based cis/vinorelbine	Cisplatin + X X: all possible
Carbo/paclitaxel in pts with comorbidities	Carboplatin-based not recommended	Carboplatin-based in pts with comorbidities
3-4 cycles cis > 300mg/m^2	4 cycles NCIC schedule	4 cycles platin-combination

V. Performance of adjuvant chemotherapy

ESMO	ASCO	NCCN
Cisplatin + vinorelbine	Cisplatin + vinorelbine	Cisplatin + vino Cisplatin + eto
No schema given	NCIC schedule preferred Cis 50 mg/m² d 1 + 8	Other cis or carbo combinations possible
		Cisplatin + pemetrexed possible

VI. Indication of postoperative radiotherapy

ESMO	ASCO	NCCN
routine use of PORT is unprooven	routine use of PORT not recommended	routine use of PORT not recommended
not in stages I and II	not in stages I and II	not in stages I and II
in IIIA(N2) PORT can be considered	in stage IIIA no routine use of PORT	PORT possible in stage IIIA

Locally advanced stage III

I. Diagnostic approaches to stage III

ESMO	ASCO	NCCN
CT & PET bronchoscopy	NA	CT & PET bronchoscopy
If suscicious nodes EBUS / EUS	NA	If suspicious nodes EBUS / EUS
CT / PET + EBUS / EUS – mediastinoscopy	NA	CT / PET + EBUS / EUS – mediastinoscopy

II. Subdivision of stage III

ESMO	ASCO	NCCN
potentially resectable	resectable	resectable
unresectable	unresectable	medically inoperable unresectable
other broad eg. superior sulcus	other broad eg. superior sulcus	other, very specific, eg. superior sulcus

Unresectable stage III

I. Chemotherapy in unresectable stage III - 1

ESMO	ASCO	NCCN
in IIIA / IIIB routinely	In IIIA / IIIB routinely	in IIIA / IIIB routinely
definitive C/RTx 2-4 cycles cisplatin-based cis / vinca cis / etop	definitive C/RTx 2-4 cycles platinum-based Carbo-regimen allowed	Definitive C/RTx all cis-based 2-drug regimen carbo/pacli allowed
no pem regimen	no pem regimen	cis/pem or carbo/pem

II. Chemotherapy in unresectable stage III - 2

ESMO	ASCO	NCCN
no consolidation with doce or gefitinib	no discussion of consolidation	no consolidation with doce or gefi
consolidation with cisplatin and etoposide discussed	NA	consolidation with carbo / pacli and cis / etoposide discussed
2-4 cycles CTx	4 cycles CTx	2-4 cycles of CTx

III. Radiotherapy in unresectable stage III - 1

ESMO	ASCO	NCCN
> 60 Gy	> 60 Gy	> 60 Gy 60-70 Gy
1,8-2,0 Gy fractions	1,8-2,0 Gy fractions standard qd	1,8-2,0 Gy fractions acceleration possible
RTOG trial data not included	RTOG trial data not included	RTOG trial data not included

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IV. Radiotherapy in unresectable stage III - 2

ESMO	ASCO	NCCN
medically unfit	medically unfit	frail, medically unfit
sequential approaches allowed	sequential approaches allowed	sequential approaches allowed
induction chemo cisplatin-based	induction chemo platin-based	all CTx regimen discussed

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Potentially resectable stage III

I. surgery in resectable stage III (N2) - 1

ESMO	ASCO	NCCN
surgery optional	surgery recommended upfront	surgery possible
induction therapy with CTx or CTx/RTx possible	no induction discussed	induction therapy with CTx or CTx/RTx possible
lobectomy preferred, center experience def. CTx/RTx alternative option	no induction discussed rather definitive CTx/RTx	alternative to definitive chemoradiation

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II. PORT in resectable stage III(N2) - 2

ESMO	ASCO	NCCN
routine use of PORT is unprooven	routine use of PORT not recommended	routine use of PORT not recommended
not in stages I and II	not in stages I and II	not in stages I and II
In IIIA(N2) PORT can be considered	In stage IIIA no routine use of PORT	PORT possible in stage IIIA (N2)

Comparison between practice guidelines

ESMO	ASCO	NCCN
major principles addresed	not detailed	very detailed "cook-book style"
multidisciplinary European experts from major institutions participated	multidisciplinary panel of experts from the US	broad multidisciplinary panel from US
evidence based but very pragmatical approach	evidence based	some recommendations only represent expert opinion

Summary - 1

- no practice guideline is on its own optimal
- all three rather complement each other
- they span from pure evidence based (ASCO) to very practical / pragmatical (NCCN) with even rare szenarios covered
- when choosing the guideline for guidance one needs ot have an idea what his needs end expectations are !

Summary - 2

- several countries in Europe have national guidelines with impact in their health care systems: eg. UK (NICE), Germany (S3-guide line)
- a fair number of European centers have individual experience and expertise in specific settings including own data sets or own long-term survivor databases
- these centers typically break down the guidelines to their local logistics

My personal bis towards evidence based medicine

“Everyday I have to make at least five descisions where there will NEVER be a phase-II trial, NEVER a randomized trial and IN NO WAY a future META-ANALYSIS“.....

Quote me for that !