

DISCUSSION

Overtreatment of patients with clinically diagnosed early stage lung cancer

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DISCLOSURE SLIDE

I have nothing to declare

IS HISTOLOGICAL DIAGNOSIS REALLY NECESSARY?

- ♦ **Recent literature:** pre-SABR histological diagnosis missing in 8%-100% of the patients depending on cardiopulmonary function –Boily et al. JTO 2015
- ♦ **Overlapping outcomes** between biopsy-proven and not histologically diagnosed lung cancer SABR treated patients. Takeda A, et al. Lung Cancer. 2012. Fischer-Valuck BW, et al. Tumori. 2015; Haidar YM, et al. Ther Adv Respir Dis. 2014.
- ♦ **Issues with treating undiagnosed patients:**
 - ♦ Significant acute and chronic toxicities in compromised patients especially for SABR in *no-fly-zone*
 - ♦ Retrospective analysis of non homogenous patient cohorts
 - ♦ Overall (3yr) rather than cancer specific survival reported
 - ♦ Relatively short median follow-up

AUTHORS' CONCLUSIONS ON SEER PATIENTS

- ◆ The disparity in cancer specific survival between clinically versus pathologically diagnosed patients may be due to a greater number of patients in the clinical diagnosis arm having benign disease which precludes them from developing a cancer related death
- ◆ This becomes an increasingly important observation and potential limitation of current clinical practice
- ◆ Note: The SEER registry does not include data on comorbidities, performance status, margin status, radiation dose, or chemotherapy use. Serious propensity score analysis in this context is difficult

QUESTIONS

- ♦ What were, if any, the acute and chronic toxicities reported in non histologically diagnosed patients undergoing SABR?
- ♦ Could you perform a stratification of CSS between SABR treated peripheral vs central tumors ?
- ♦ Is the 17 month median follow-up acceptable to draw definitive conclusions from your paper?
- ♦ Based on your findings, would you suggest a critical revision of the manuscripts reporting outcomes of SABR in mixed population (diagnosed and non diagnosed) and possibly focus on histologically proven patients from now on?
- ♦ Should we abandon reporting OS in favor of CSS?
- ♦ Which implications do you see in clinical practice?

DISCUSSION

**Extended pleurectomy decortication for malignant
pleural mesothelioma in the elderly –
the need for an inclusive yet selective approach**

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Multimodal management of malignant pleural mesothelioma: where are we today?

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TABLE 2 Summary of key points obtained by consensus at the meeting of International Mesothelioma Interest Group in 2012 [12]

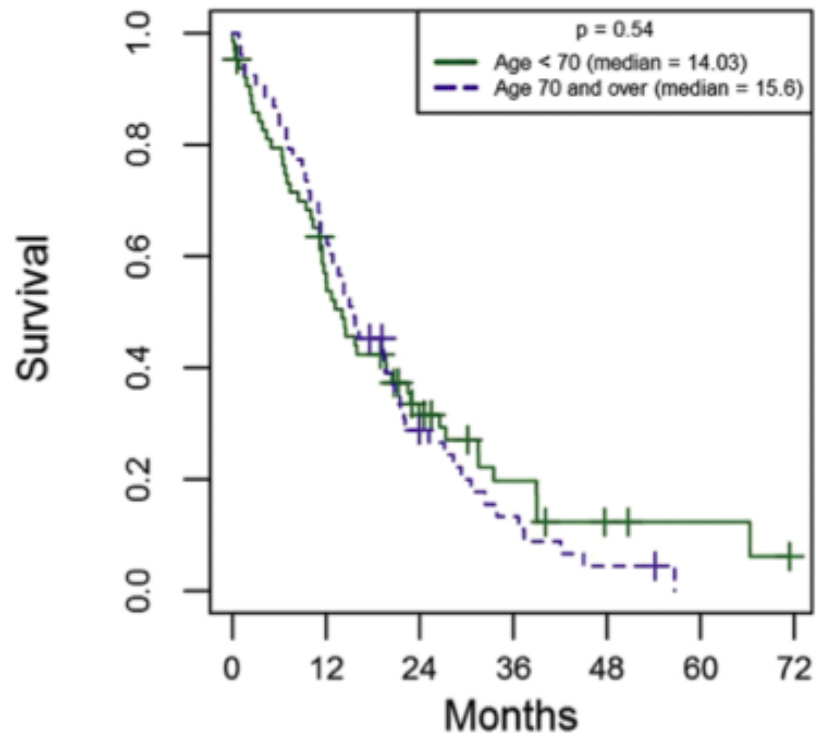
Every patient with presumed mesothelioma should be discussed by a multidisciplinary tumour board

Histology and precise clinical staging should be obtained before initiating therapy

Macroscopic complete resection and control of micrometastatic disease are the main goals of extended surgical treatment within the setting of combined-modality therapy

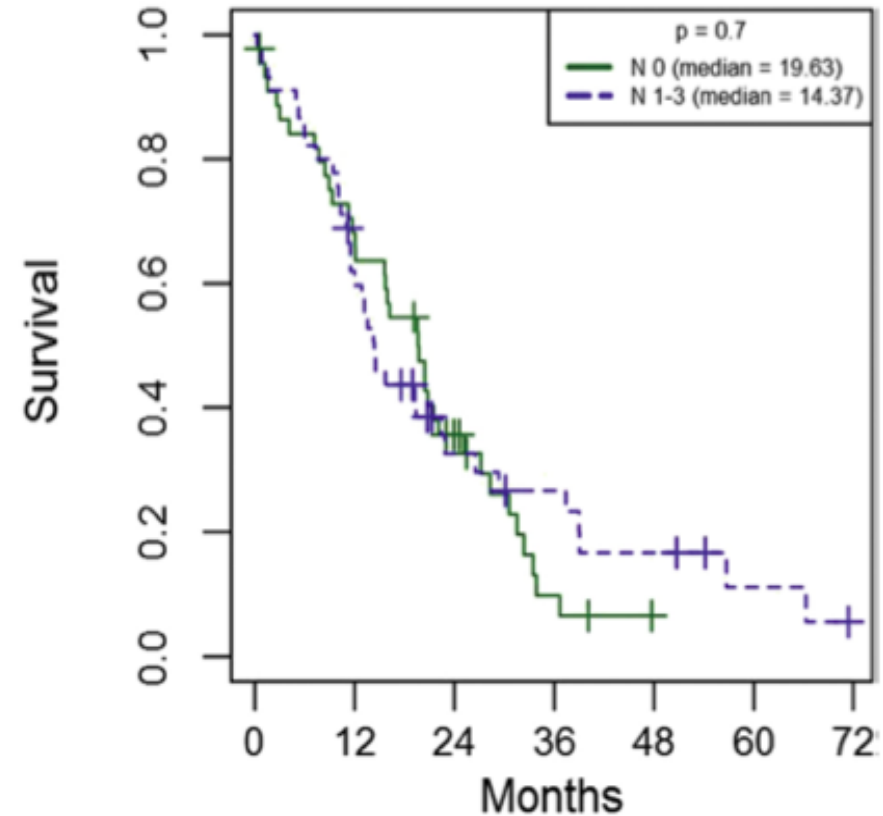
For operable patients, the choice of surgical procedure (EPP or P/D) largely depends on clinical features, individual surgical evaluation, and expertise of the surgeon and centre where the patient is treated

EPP: extrapleural pneumonectomy; P/D: pleurectomy/decortication.



Age < 70 — 64 35 16 8 3 2
Age 70 and over - - 53 34 13 6 2

Fig 1. Kaplan-Meier survival curves for patients 70 years and older (blue dashed line) and those younger than 70 years (green solid line).



N 0 — 45 30 13 3
N 1-3 - - 45 27 11 8 5 2

Fig 3. Kaplan-Meier survival curves stratified by node-positive (N1–N3, blue dashed line) and node-negative (N0, green solid line) status.

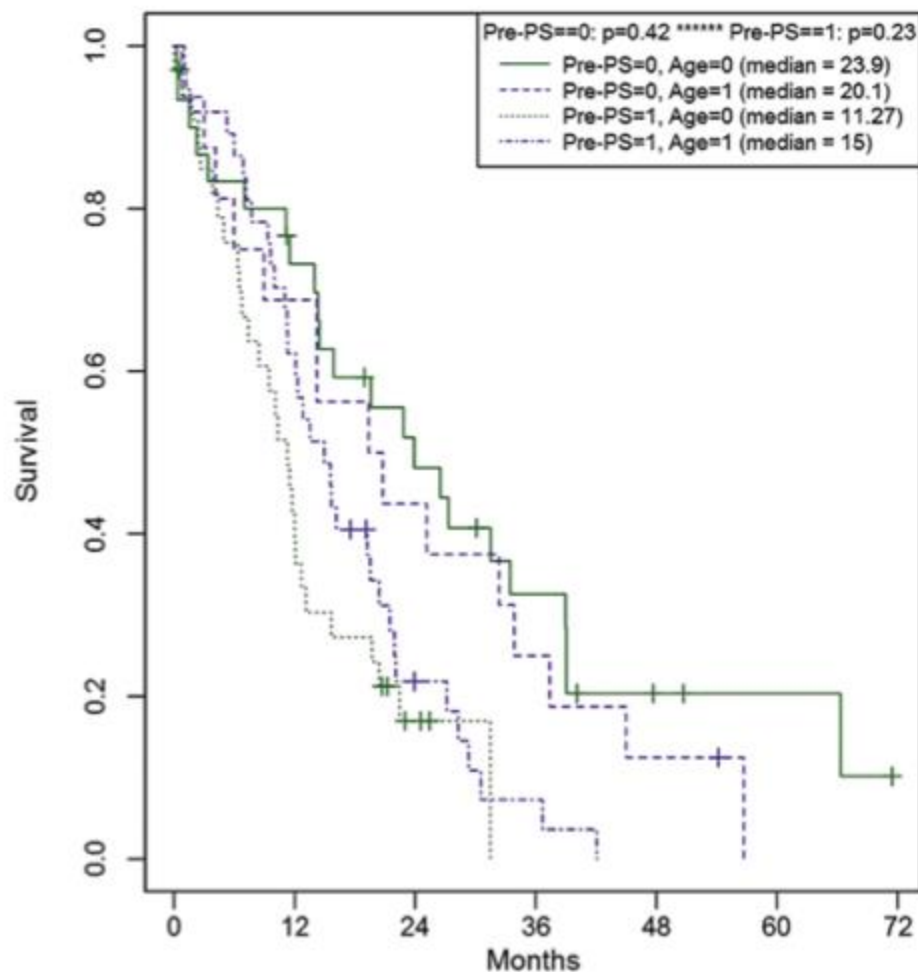


Fig 4. Kaplan-Meier survival curves stratified by age and performance status. (Green: age <70 yrs; pre-PS 0, solid line; pre-PS 1, dashed line. Blue: age 70+ yrs; pre-PS 0, long dashed line; pre-PS 1, short dashed line.)

Pre-PS=0, Age=0 (median = 23.9)	30	21	13	8	3	2
Pre-PS=0, Age=1 (median = 20.1)	16	11	7	4	2	
Pre-PS=1, Age=0 (median = 11.27)	34	14	3			
Pre-PS=1, Age=1 (median = 15)	37	23	6	2		

(Ann Thorac Surg 2015;100:1868–74)

IF ANYTHING, WHY EPD?

- ♦ If a macroscopic complete resection is achievable, EPD is preferred over EPP due to reduced morbidity and mortality (Burt et al 2014)
- ♦ In patients with minimal symptoms, EPD may generate worsening of pulmonary function and quality of life
- ♦ In symptomatic patients, EPD generates a significant and lasting improvement of QoL whereas pulmonary function is unaffected (Burkholder et al 2015)
- ♦ Transition from EPP to EPD may enable surgeons to offer a surgical option to more patients with PS1 and characterized by a better survival in the elderly (>65 yo) compared to younger cohorts (EJCTS 2016).

QUESTIONS

- ◆ Concept of **elderly** different in other publications (65 yo in your EJCTS 2016) – no differences in cohort analysis using the 70 year cutoff. Why choosing a different age cutoff? How did you select the patients for surgery, ie, do you have an institutional algorithm vs score?
- ◆ Have you looked at performing a propensity score analysis ?
- ◆ What routine risk assessment model do you adopt? Is CPET standard for preoperative evaluation of these elderly patients? What is the impact of patient's preference in surgical decision-making?
- ◆ How many of these procedures have been done by VATS?
- ◆ In your transition from EPP to EPD (EJCTS 2016), you have noticed an increasing late reoperation rate for EPD – does this apply to the elderly category and how does this affect the subjective and objective outcomes?