



IIIA-N2 HASTALARDA TRİMODALİTE TEDAVİDE SON DURUM

TEDAVİ AŞAMALARI	TARTIŞMA KONUSU	PROBLEM
N2 KHDK	TEK İSTASYON MİNİMAL N2	TRİMODALİTE DİĞER TEDAVİLERDEN DAHA İYİ Mİ? DATA YOK.ÇOĞU FAZ II-III ÇALIŞMADA BULKY N2 AĞIRLIKLI
İNDÜKSİYON TEDAVİSİ	KT VEYA KTRT, EN İYİ TEDAVİ DOZU /KT REJİMİ?	YETERLİ VERİ YOK YETERLİ VERİ YOK
RESTAGING	MEDİASTİNAL DOWNSTAGING SAPTANMASI	PRİMER MEDİASTİNOSKOPI DIŞINDA HIÇBİRİ GÜVENİLİR DEĞİL (EUS/EBUS/REMEDİASTİNOSKOPI/ PET.. HEPSİNDE FALSE (-) ORANI ↑
PERSİSTENT N2	KÖTÜ CEVAP → REZEKSİYON YAPILMAMALI MI? KÖTÜ CEVAP → REZEKSİYON YAPILMALI MI?	BU SORUNUN CEVABI İÇİN VERİYOK
DOWNSTAGING	İYİ CEVAP → REZEKSİYON YAPILMALI MI? İYİ CEVAP → REZEKSİYON YAPILMAMALI MI?	BU SORUNUN CEVABI İÇİN VERİ YOK
REZEKSİYON VE LENF DİSEKSİYONU	PERİOPERATİF MORTALİTE REZEKSİYON İLK HALE GÖRE Mİ SON HALE GÖRE Mİ YAPILMALI?	YÜKSEKSE ONKOLOJİK YARARI SİLEBİLİR YETERLİ VERİ YOK
ADJUVAN TEDAVİ	KT? RT?	YETERLİ VERİ YOK TARTIŞMALI

CHEST[®]

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Treatment of Non-small Cell Lung Cancer-Stage IIIA: ACCP Evidence-Based Clinical Practice Guidelines (2nd Edition)

Lary A. Robinson, John C. Ruckdeschel, Henry Wagner, Jr and Craig W. Stevens

Chest 2007;132;243-265

In NSCLC patients with N2 disease identified Preoperatively, platinum-based combination chemoradiotherapy is recommended as primary treatment”



European Society
for Medical Oncology

“In NSCLC patients with cN2 disease
neoadjuvant chemotherapy is standard
treatment”



PRINCIPLES OF SURGICAL THERAPY (3 of 4)

The Role of Surgery in Patients With Stage IIIA (N2) NSCLC

- Repeat mediastinoscopy, while possible, is technically difficult and has a lower accuracy compared to primary mediastinoscopy. One possible strategy is to perform EBUS (\pm EUS) in the initial pretreatment evaluation and reserve mediastinoscopy for nodal restaging after neoadjuvant therapy.⁵
- Patients with a single lymph node smaller than 3 cm can be considered for a multimodality approach that includes surgical resection.^{1,6,7}
- Restaging after induction therapy is difficult to interpret, but CT +/- PET should be performed to exclude disease progression or interval development of metastatic disease.
- Patients with negative mediastinum after neoadjuvant therapy have a better prognosis.^{7,8}
- Neoadjuvant chemoradiotherapy is used in 50% of the NCCN institutions, while neoadjuvant chemotherapy is used in the other 50%. Overall survival appears similar provided RT is given postoperatively, if not given preoperatively.^{5,9} Neoadjuvant chemoradiotherapy is associated with higher rates of pathologic complete response and negative mediastinal lymph nodes.¹⁰ However, that is achieved at the expense of higher rates of acute toxicity and increased cost.
- When neoadjuvant chemoradiotherapy is used with doses lower than those used for standard definitive therapy, all efforts should be made to minimize any possible breaks in radiotherapy for surgical evaluation. Treatment breaks of more than 1 week are considered unacceptable.
- When timely surgical evaluation is not available, the strategy of neoadjuvant chemoradiotherapy should not be used. Another option in individual cases, and with the agreement of the thoracic surgeon, is to complete definitive chemoradiotherapy prior to re-evaluation and consideration for surgery.^{11,12} If a surgeon or center is uncertain about the feasibility or safety of resection after definitive doses of radiation, consider obtaining an additional surgical opinion from a high-volume specialized center. These operations may also benefit from additional considerations of soft tissue flap coverage in the radiation field resection.
- Data from a large multi-institutional trial indicate that pneumonectomy after neoadjuvant chemoradiotherapy has unacceptable morbidity and mortality.² However, it is not clear if this is also true with neoadjuvant chemotherapy alone. Further, many groups have challenged that cooperative group finding with single institution experiences demonstrating safety of pneumonectomy after induction therapy.¹³⁻¹⁶ In addition, there is no evidence that adding RT to induction regimens for patients with operable stage IIIA (N2) disease improves outcomes compared to induction chemotherapy.¹⁷

A questionnaire was submitted to the NCCN institutions in 2010 regarding their approach to patients with N2 disease. Their responses indicate the patterns of practice when approaching this difficult clinical problem.

- a) Would consider surgery in patients with one N2 lymph node station involved by a lymph node smaller than 3 cm: (90.5%)
- b) Would consider surgery with more than one N2 lymph node station involved, as long as no lymph node was bigger than 3 cm: (47.6%)
- c) Uses EBUS (+/- EUS) in the initial evaluation of the mediastinum: (80%)
- d) Uses pathologic evaluation of the mediastinum, after neoadjuvant therapy, to make a final decision before surgery: (40.5%)
- e) Would consider neoadjuvant therapy followed by surgery when a patient is likely, based on initial evaluation, to require a pneumonectomy: (54.8%)



greater than 3 cm; definitive chemoradiotherapy is recommended for these patients.

The NCCN Panel believes that surgery may be appropriate for select patients with N2 disease, especially those who respond to induction chemotherapy (see *Principles of Surgical Therapy* in the NCCN NSCLC algorithm).^{142,169} However, it is controversial whether pneumonectomy after neoadjuvant chemoradiotherapy is appropriate.^{164,169-175} Patients with resectable N2 disease should not be excluded from surgery, because some of them may have long-term survival or may be cured.^{169,176}

discharge independence in older populations and in high-risk patients.^{198,199} Data show that thorascopic lobectomy improves the ability of patients to complete postoperative chemotherapy regimens.^{200,201} Based on its favorable effects on postoperative recovery and morbidity, thorascopic lobectomy is recommended in the NCCN NSCLC algorithm as an acceptable approach for patients who are surgically resectable (and have no anatomic or surgical contraindications) as long as standard principles of thoracic surgery are not compromised (see *Principles of Surgical Therapy*).

Radiation Therapy



The Role of Surgery in Patients With Stage IIIA (N2) NSCLC

The role of surgery in patients with pathologically documented N2 disease remains controversial.¹ Two randomized trials evaluated the role of surgery in this population, but neither showed an overall survival benefit with the use of surgery.^{2,3} However, this population is heterogeneous and the panel believes that these trials did not sufficiently evaluate the nuances present with the heterogeneity of N2 disease and the likely oncologic benefit of surgery in specific clinical situations.

- The presence or absence of N2 disease should be vigorously determined by both radiologic and invasive staging prior to the initiation of therapy since the presence of mediastinal nodal disease has a profound impact on prognosis and treatment decisions. (NSCL-1, NSCL-2, and NSCL-6)
 - Patients with occult positive N2 nodes discovered at the time of pulmonary resection should continue with the planned resection along with formal mediastinal lymph node dissection. If N2 disease is noted in patients undergoing VATS, the surgeon may consider stopping the procedure so that induction therapy can be administered before surgery; however, continuing the procedure is also an option.
 - The determination of the role of surgery in a patient with N2 positive lymph nodes should be made prior to the initiation of any therapy by a multidisciplinary team, including a board-certified thoracic surgeon who has a major part of his/her practice dedicated to thoracic oncology.⁴
 - The presence of N2 positive lymph nodes substantially increases the likelihood of positive N3 lymph nodes. Pathologic evaluation of the mediastinum must include evaluation of the subcarinal station and contralateral lymph nodes. EBUS +/- EUS are additional techniques for minimally invasive pathologic mediastinal staging that are complementary to mediastinoscopy. Even when these modalities are employed it is important to have an adequate evaluation of the number of stations involved and biopsy and documentation of negative contralateral lymph node involvement prior to a final treatment decision.
-

Management of Stage IIIA NSCLC by Thoracic Surgeons in North America

- Web based survey of 2539 active surgeons
- 513 response rate (20%) (43% academic practice)

In a patient with normal pulmonary function tests requiring pneumonectomy in the presence of single station N2 disease:

Percentage of respondents	N	Therapy	Comments
• 32%	163	Induction -> Lobectomy	if N0
• 30%	159	Induction -> PX	if N0
• 12%	60	Induction -> PX	any N !
• 22%	114	Chemo+RT	



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Physician Preferences for Management of Patients with Stage IIIA NSCLC: Impact of Bulk of Nodal Disease on Therapy Selection

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Abstract

Introduction—Stage IIIA non-small cell lung cancer (NSCLC) is comprised of a heterogeneous group of patients with predominant ipsilateral mediastinal (N2) disease. The spectrum of lymph node presentation has led to a host of trials involving various therapeutic combinations and optimal management has been unclear.

Methods—In 2007 and 2008, ten live research events surveyed the practice preferences of American medical oncologists using two hypothetical scenarios. The first scenario was of a stage IIIA NSCLC in the right upper lobe with a single enlarged (>1cm) 4R lymph node found to be malignant by mediastinoscopy. The second was of a bulky stage IIIA NSCLC with multi-station N2 pathologically positive nodes.

Results—In the first scenario, 373 (92%) of the oncologists incorporated surgery into their treatment plan. Only 34 (8%) offered chemoradiotherapy alone. Neoadjuvant chemotherapy, followed by surgery, then additional chemoradiotherapy (32%) was the most commonly offered treatment strategy. In the second scenario, 209 (52%) medical oncologists chose definitive chemoradiation. 193(48%) included surgery as part of the treatment plan.

Conclusions—The current standard of care for IIIA N2 NSCLC recognized prior to treatment is concurrent chemoradiotherapy. This study demonstrated that a significant proportion of oncologists treating locally advanced lung cancer include surgery in as part of the treatment plan more so in single versus multi-nodal station disease. Since node positive locally advanced disease is such a common presentation for patients with lung cancer, well-designed clinical trials are needed to define the most advantageous treatment strategy for individual subsets of patients with Stage IIIA disease.

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Guidelines on the radical management of patients with lung cancer

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1.2.4 N3 disease

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3.1.1 Risks of radical radiotherapy

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1.2.3 N2 disease

25. Consider radical radiotherapy or chemoradiotherapy in patients with T1–4N2 (bulky or fixed) M0 disease. **[B]**

26. Consider surgery as part of multimodality management in patients with T1–3N2 (non-fixed, non-bulky, single zone) M0 disease. **[B]**

27. **RR** Consider further randomised trials of surgery added to multimodality management in patients with multi-zone N2 disease to establish if any subgroups of patients might benefit more from the addition of surgery.



- **You give chemoradiotherapy to a lot of patients who don't benefit and we operate on patients who don't benefit. Unfortunately, we treat a disease where we lose more often than we win.**

Dr. De Camp, Massachusetts, 2004



DENEMEDEN BAŞARAMAZSINIZ





YORUMSUZ

