JADPRO CE Regional Education

From Inquiry to Investigation to Insight: Clinical Clarity in Non–Small Cell Lung Cancer

Consult the Experts: Case Challenges From Conference Participants

Program Chair

Beth Eaby-Sandy
MSN, CRNP
Abramson Cancer Center

Faculty

Tyler Beardslee, PharmD
Winship Cancer Institute at Emory University

Marianne Davies
DNP, ACNP, AOCNP®
Yale School of Nursing

Elizabeth Gilbert
MS, PA-C
Abramson Cancer Center

Rasheda Persinger, NP-C
Johns Hopkins Sidney Kimmel Cancer Center

Faculty Financial Disclosures

- **Ms. Eaby-Sandy** has served as a consultant and on speakers bureaus for AstraZeneca, Helsinn, Merck, and Takeda.
- **Dr. Beardslee** has served as a consultant for AstraZeneca and Herron, and on the speakers bureau for AstraZeneca.
- **Dr. Davies** has served on speakers bureaus for AstraZeneca, Bristol-Myers Squibb, Genentech, and Merck.
- **Ms. Gilbert** has no conflicts of interest to disclose.
- **Ms. Persinger** has served on speakers bureaus for Genentech and Guardant Health, and on the advisory board for AstraZeneca.

Planning Committee Financial Disclosures

- Elizabeth Waxman, RN, MSN, AOCN®, ANP-BC, has nothing to disclose.
- Dorothy Caputo, MA, BSN, RN (Lead Nurse Planner) has nothing to disclose.
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Learning Objectives

- Select therapy in accordance with evidence-based best practices

Attendee-Submitted Case Study

- We saw a patient for a second opinion for metastatic NSCLC. He came to us from an outside hospital and had not had molecular testing done.
- We requested the tissue but it was very delayed in arriving to us.
- In the meantime, the patient and the family wanted to start treatment and we had a first-line trial available that included chemotherapy with immunotherapy. He proceeded and received cycle # 1.
- The week after starting we received results of molecular testing which indicated that he had an *ALK* mutation.
- Should we take him off the trial and start him on an ALK inhibitor? One concern we have is reports that toxicity from the ALK drug could be worse because of the immunotherapy he has just had. What would you recommend?

Case Study of Oligometastatic NSCLC: Mr. Oligo

- 58 year old with adenocarcinoma, PD-L1 negative, no molecular alterations, good ECOG PS.
- Presents with a 4-cm RUL mass, negative EBUS. MRI brain positive for 2 foci of brain mets and PET+ for one hot area in the R femur (small, no cortical erosion, asymptomatic).

RUL = right upper lobe; EBUS = endobronchial ultrasound

Audience Response Question

58 year old with adenocarcinoma, PD-L1 negative, no molecular alterations, good ECOG PS. Presents with a 4-cm RUL mass, negative EBUS. MRI brain positive for 2 foci of brain mets and PET+ for one hot area in the R femur (small, no cortical erosion, asymptomatic).

What are your treatment options?

A. Treat as metastatic dx
B. Treat with surgery, followed by SRS to brain and SBRT to femur
C. Treat with B and add a year of immunotherapy
D. Treat with concurrent chemo/radiation to the chest followed by immunotherapy

RUL = right upper lobe; EBUS = endobronchial ultrasound; SRS = stereotactic radiosurgery; SBRT = stereotactic body radiation therapy.

Audience Response Question

Let's say Mr. Oligo (4-cm RUL mass with 2 brain and 1 bone met) has a positive EBUS with N2 disease. What are your treatment options?

A. Treat as metastatic dx
B. Treat with surgery, followed by SRS to brain and SBRT to femur
C. Treat with B and add a year of immunotherapy
D. Treat with concurrent chemo/radiation to the chest followed by immunotherapy and radiate the bone and brain mets before the durva

Audience Response Question

On durvalumab post chemo/radiation. TSH rises on 3rd month from baseline of 1.5 to 8.9 over a 2-week interval. Patient is asymptomatic, you would:

A. Continue to monitor
B. Check further TFT panel
C. Initiate levothyroxine