Greater Manchester Cancer

Guidance for the selection and pathway overview for patients with stage III-N2 NSCLC suitable for trimodality treatment

Introduction

In 2019 the National Institute for Health and Care Excellence (NICE) published its updated guidance for the diagnosis and management of lung cancer. This included a specific new recommendation for the management of patients with stage III-N2 NSCLC that are considered potentially resectable. Such patients can be considered for trimodality treatment (chemoradiotherapy followed by surgery). This is a highly intensive multi-modality treatment regime and one that is not currently used within routine clinic practice. Stage III NSCLC lung cancer is also a rapidly evolving field with new treatment paradigms (particularly in non-surgical treatment regimens) beginning to enter routine clinical practice. Therefore, patient selection, patient choice, shared decision making and access to appropriate expertise is critical in ensuring the very best patient outcomes.

This document, produced by a dedicated N2 taskforce, a sub-group of the Greater Manchester Cancer Lung Pathway Board, provides guidance on patient selection and referral, a standardised definition of 'potentially resectable' stage III-N2 NSCLC for all MDTs use within their case discussions and an overview of the agreed pathway to facilitate rapid and efficient transition from chemoradiotherapy to surgery. **The target is to complete surgery within 3-5 weeks of completing chemoradiotherapy as per NICE guidance.**

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Recommendations for patient selection for trimodality treatment in N2 NSCLC at Sector MDT discussion

MDT agreed Stage III N2 NSCLC and considered 'potentially resectable' in line with the GM standardised definition

AND:

- Deemed suitable for radiotherapy e.g. acceptable disease volume, absence of interstitial lung disease, absence of mediastinal vessel involvement
- Deemed suitable for chemotherapy e.g. adequate renal function, no hearing impairment
- Adequate physiological reserve for trimodality treatment*
- Absence of poor prognostic markers e.g. >10% weight loss
- Ability to travel and engage with multiple hospital visits at different trusts
- Appropriate social support during mulit-modality treatment

Recommended parameters of adequate physiological reserve for trimodality treatment:

- ✓ **PS 0-1**
- ✓ **Post-operative predicted lung function >40%**
- ✓ **Shuttle walk >400m or VO2 max >15mls/kg/min**
- ✓ **Normal left ventricular function on echocardiogram**
- ✓ **BMI >20**
- ✓ **Clinical frailty score 1-3**

Please note these are guidelines for patient selection for trimodality treatment. Given the highly individual patient and disease factors in every case of N2 NSCLC, the final decision and treatment recommendation rests in the expert hands of the sector MDT.

Patients identified as potentially suitable for trimodality treatment should be referred to both thoracic surgery and thoracic oncology teams as per the trimodality pathway.

Please ensure referrals for consideration of trimodality treatment include:

- ✓ **PDL1 status**
- ✓ **History of any autoimmune condition and its severity**
- ✓ **History of any corticosteroid use**

Please ensure all patients have been provided with the necessary interventions to optimise for multi-modality treatment such as treatment for tobacco addiction, nutritional assessment and support and physical activity interventions.

NOTE: the PIONEER trial will open in 2020 and is a randomised controlled trial of surgical (including trimodality treatment) versus non-surgical multi-modality treatment in N2 NSCLC with a quality of life primary outcome. The North West and South Sector MDTs will actively recruit to this trial but we will happily facilitate rapid review of patients from across GM wishing to consider this trial – please contact **Matt Evison (m.evison@nhs.net)** or **Seamus Grundy (seamus.grundy@srft.nhs.uk)**.

Please support randomisation to this important trial.

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Greater Manchester Cancer Guidelines
Definition of potentially resectable N2 NSCLC

- Pathologically confirmed N2 lymph node disease as part of a systematic nodal staging procedure (surgical or endoscopic) (single or multistation)
- Thorough radiological staging including at least positron emission tomography (PET)-CT and MR brain with contrast
- Primary tumour deemed resectable with high probability of clear pathological margins and complete resection, preferably avoiding a pneumonectomy
- Easily measurable and defined metastatic N2 lymph nodes free from major mediastinal structures including the great vessels and trachea with no individual lymph node measuring >3 cm.
- **Ultimately the assessment of resectability rests with the thoracic surgical team present in the MDT and then on face to face consultation with the patient**

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Greater Manchester Trimodality Treatment Pathway
Stage III – N2 Non-small Cell Lung Cancer

1

Sector MDT

Patient identified as possible candidate for trimodality treatment
Refer to Oncology and Thoracic Surgery to confirm suitability & discuss options

2

Patient & clinicians agree to proceed with trimodality treatment

Chemoradiotherapy commences at The Christie

3

Referral to RAPID hub at Wythenshawe Hospital

Responsible oncologist emails referral to
mft.rapidlungdiagnostic@nhs.net & m.evison@nhs.net with finishing date for CRT

4

Date for post-chemoradiotherapy imaging confirmed

Patient is booked for contrast-enhanced CT brain, chest, abdomen & pelvis in one scan in the RAPID hub - date fed back to referring oncologist and Jackie Fenemore, Lead CNS at The Christie, jackie.fenemore@christie.nhs.uk (information is added to CWP at The Christie).
Patient is contacted with date - 7 days following finishing CRT.

5

RAPID team contact patient 2 working days prior to appointment to check patient able to attend

6

Post-chemoradiotherapy imaging & review*

Patient attends for RAPID scan - **hot reported and clinical review same morning**.
If no distant progression and no clear local progression to unresectable, patient is booked for

Surgical OP appointment within 3 working days

Patient & surgeon agree to proceed with surgery. Listed for surgery.
Prioritised as urgent: **surgery within 14 days.**

7

Completion of trimodality treatment

Standard surgical follow-up and then returned to follow up of oncology team and local physician.

**Contrast enhanced CT imaging only - no indication for PET-CT, MR brain, nodal staging. Does not require post - CRT MDT discussion, proceed straight to imaging and surgical assessment.*

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