



# A MEDICAL ONCOLOGIST'S CHECKLIST

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## Treatment & Management of Unresectable Stage III NSCLC

This guide was developed with two medical oncologists, Devon L. Evans, MD, and Christopher S. Ho, MD, based on their experience and practice and does not express the views and opinions of AstraZeneca. It should not take the place of your clinical judgment. These are general recommendations for educational purposes only. Individual recommendations for patients may vary.

## ABOUT THIS GUIDE



### Devon L. Evans, MD

Hematologist and Medical Oncologist  
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Dr Devon Evans grew up in rural Massachusetts and went to Jefferson Medical College in Philadelphia. He did his Residency at Beth Israel Deaconess in Boston, and his Fellowship at Brown University Medical Center in Rhode Island. Dr Evans is board certified in hematology and oncology, with interests in lung cancer, gastrointestinal cancers, and brain tumors. He is a member of the American Society of Clinical Oncology, the Society for NeuroOncology, and the Alpha Omega Alpha Honor Medical Society.

According to Dr Evans, “I became an oncologist with the hope of providing comfort and strength to those made vulnerable by a challenging disease. I am amazed every day by my patients as they fight to live their lives in spite of their cancer, and refuse to let it define them. Their courage remains my inspiration.”

Dr Evans lives in Cape Elizabeth with his wife and three daughters. His outside interests center on enjoying the wonderful outdoor attractions of Maine with his family: skiing in the winter, and running, swimming and boating during the summer.



### Christopher S. Ho, MD

Hematologist and Medical Oncologist  
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Dr Christopher Ho was born and raised in Philadelphia. He earned his undergraduate degree from Johns Hopkins University and his Doctor of Medicine from Temple University. He clerked at the Fox Chase Cancer Center in Philadelphia, an experience that ignited his interest in medical oncology research. After residency at the University of California, Davis, Dr Ho received subspecialty training in medical oncology and hematology at USC's Keck School of Medicine, where he served as chief fellow of medical oncology. Dr Ho is certified by the American Board of Internal Medicine, the American Board of Medical Oncology, and the American Board of Hematology. He is a member of the Medical Oncology Association of Southern California, the American Society of Hematology, and the American Society of Clinical Oncology.

Dr Ho has dedicated himself to the belief that the health of every one of his patients depends on a comprehensive, personalized approach to care that includes a combination of the latest treatment techniques and the personal touch of a physician who truly cares.

Because of his wide range of interests, including music, nutrition, calisthenics, Philadelphia Eagles football, and gourmet food, Dr Ho is able to connect easily with his patients and share insightful conversations. He is a devoted family man, spending as much time as possible with his wife and two young sons. He speaks English, Spanish, and Chinese.

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## GENERAL TIPS FOR PRIVATE PRACTICE/COMMUNITY SETTING MEDICAL ONCOLOGISTS

- Medical oncologists often serve a centralized role within the multidisciplinary team (MDT) that treats patients with unresectable Stage III non-small cell lung cancer (NSCLC). To enhance patient care, a medical oncologist may promote an open network within the treatment team by<sup>1\*</sup>:
  - » Understanding how team members operate and communicate in their day-to-day practice, especially in terms of availability and timing
  - » Knowing resources available within their medical community
  - » Communicating with MDT members before referring patients to them
  - » Encouraging quick exchanges during which patient progress or concerns can be relayed or resolved
- Obtain rapid referrals from both the primary care physician (PCP), thoracic surgeon and pulmonologist when the patient is referred to the medical oncologist<sup>2</sup>
- Assure timely referral to a radiation oncologist to determine eligibility\*

### NOTES

\*General guidance gathered from discussions with two physicians based on their opinions and experience.

## 1 ENGAGEMENTS WITH PCP OR PULMONOLOGIST ABOUT REFERRALS

- ❑ Inform PCPs and pulmonologists that unresectable Stage III NSCLC is a curative-intent setting for eligible patients<sup>3\*</sup>
- ❑ Educate PCPs and pulmonologists about treatment options (eg, intensity-modulated radiation therapy [IMRT] and consolidation immunotherapy for patients who are eligible based on post-concurrent chemoradiation therapy [post-cCRT] computed tomography [CT] scan results with no evidence of disease progression) so that they relay timely medical information to patients<sup>4,5\*</sup>
  - » Patients who lack awareness of medical advancements in cancer care may decline to receive potentially beneficial treatments\*



## 2 ACCURATE MEDIASTINAL STAGING FOR ADMINISTERING THE APPROPRIATE TREATMENT

- ❑ Determine patient history, workup, and symptoms<sup>6</sup>
- ❑ Coordinate with the appropriate specialist (eg, radiologist, pulmonologist, pathologist, radiation oncologist) to obtain accurate staging (American Joint Committee on Cancer 8th TNM classification)<sup>2</sup>
  - » Systemic imaging via positron emission tomography–CT (PET-CT) of chest, abdomen, and pelvis and MRI of brain<sup>7-9</sup>
    - PET scan reports can be obtained within several hours. Coordinate with the radiation oncologist to start developing a radiation plan\*
  - » Invasive surgical-pathological staging (obtained by tissue biopsy)
    - In addition to noninvasive methods, biopsy confirmation by endobronchial ultrasound (EBUS/EUS [endoscopic ultrasound]) or mediastinoscopy to confirm cancerous lymph nodes as good practice<sup>9,10\*</sup>
      - The ultimate goal of invasive staging is to receive accurate, timely staging and it remains an important confirmation method. Mediastinoscopy and EBUS are both valuable options for this purpose, but one is not preferred over the other. Rather, availability and access to EBUS may determine which method is used\*
      - The use of minimally invasive staging methods, such as EBUS/EUS, allows for accessibility to almost all mediastinal and most hilar lymph nodes with fewer reported<sup>11,12</sup>
- ❑ Request timely notification from the appropriate specialist about the resectability of lesions so that the standard of care (cCRT) can be administered to patients with unresectable Stage III disease<sup>7\*</sup>
- ❑ Confirm that all staging is complete before going forward with the treatment plan<sup>7,13</sup>
  - » Metastasis cannot be assumed based on symptoms alone\*



Stage III NSCLC is a very heterogeneous disease that requires a multidisciplinary approach to evaluate and stage accurately.<sup>14</sup> Misstaging may inadvertently occur due to incomplete investigation of lesions, which may then lead to eligible patients missing the opportunity to receive guideline-recommended concurrent cCRT<sup>7,15\*</sup>

### 3 MULTIDISCIPLINARY DISCUSSION AND ALIGNMENT REGARDING TREATMENT RECOMMENDATION



An MDT increases the likelihood that patients receive standard of care (cCRT) for unresectable Stage III NSCLC.<sup>16</sup>

- ❑ Establish team leadership, roles, and responsibilities of each MDT member<sup>2</sup>
  - » The medical oncologist often serves as the point person of care throughout the patient's cCRT journey and may serve a de facto leadership role by gathering patient information and sharing with appropriate team members\*
  - » A clear plan of which office orders scans and tests may be essential to prevent delay in treatment\*
- ❑ Align with MDT on treatment plan (tumor board or phone call) following diagnosis of unresectable Stage III NSCLC
  - » General considerations for treatment<sup>6\*</sup>
    - Patient preferences
    - Eastern Cooperative Oncology Group performance status of patient to determine whether cCRT is appropriate
    - Prior chemotherapy and radiation therapy (if applicable)
    - Ensure a protocol for prior authorization of immunotherapy upfront after cCRT for eligible patients<sup>3,5,7\*</sup>
  - » Communication between the radiation oncologist and the medical oncologist to ensure agreement and plan before providing treatment recommendations to the patient<sup>2\*</sup>
- ❑ Determine the chemotherapy regimen based on patient profile, histology<sup>3,17,18</sup> and clinical acumen\*
  - » Choosing the appropriate drug combination to reduce the risk of side effects
    - Carboplatin + paclitaxel<sup>18,19</sup>
    - Carboplatin + pemetrexed<sup>18,19</sup>
    - Cisplatin + etoposide<sup>18,19</sup>
- » For certain patients, consider the possibility of induction with chemotherapy to shrink the tumor first\*:
  - Reduces the radiation field for adding on radiotherapy later<sup>20\*</sup>
  - May enable a patient who otherwise may not be able to initiate the standard of care for unresectable stage III NSCLC to be eligible for cCRT<sup>21\*</sup>
- ❑ Ensure all patients with unresectable Stage III NSCLC are discussed and their care coordinated with the radiation oncologist\*
  - » Encourage radiation oncologist to educate patient about the entire potential treatment regimen (eg, cCRT followed by immunotherapy, if eligible)<sup>3,5,7\*</sup>
  - » Ascertain from the radiation oncologist how the patient was evaluated and how the radiation dose was set (eg, recommendation of 60 Gy to 66 Gy for patients with unresectable Stage III NSCLC)<sup>7</sup>
  - » Develop a relationship with radiation oncologist to share relevant clinical insights and study results from reliable published sources regarding unresectable Stage III NSCLC\*
- ❑ Contact the radiation oncologist prior to presenting patient with the final treatment recommendation<sup>2\*</sup>
  - » Every patient with unresectable Stage III NSCLC should have consultations with both a medical oncologist and radiation oncologist\*
- ❑ Prior to initiation of cCRT, file appropriate paperwork for insurance coverage to prevent any delay in its initiation\*

\*General guidance gathered from discussions with two physicians based on their opinions and experience.

## 4 INITIAL DISCUSSION WITH PATIENT, CAREGIVER, AND FAMILY REGARDING OVERALL PLANS OF CARE

- ❑ Educate patients, caregivers, and family members on unresectable Stage III NSCLC and treatment options so that the patient remains empowered and informed about their health.<sup>17,22,23</sup> This should include duration of cCRT and how often scans are performed after the initial scan
  - » Nurse-led education sessions can help patients understand what to expect as they initiate their treatment plan\*
- ❑ Ensure patients, caregivers, and family members are aware that intent of treating unresectable Stage III NSCLC is curative intent<sup>3</sup>
- ❑ Inform patients, caregivers, and family members that consolidation immunotherapy is a treatment option for eligible patients after CRT and based on post-cCRT CT scan results with no evidence of disease progression<sup>3,5,7\*</sup>
- ❑ Set expectations for:
  - » Appointments with different treatment team members\*
    - Patient navigators can help schedule appointments and connect to the appropriate MDT member<sup>24</sup>
  - » Potential adverse events from cCRT<sup>19</sup>
    - Nausea, acid reflux, infection, pain (or difficulty swallowing), thickened mucus, mucositis, esophagitis, fatigue, weight loss, lack of appetite, dehydration, constipation, skin reactions, radiation pneumonitis<sup>4,25,26\*</sup>

## 5 FOLLOW-UP WITH PATIENT, CAREGIVER, AND FAMILY REGARDING OVERALL PLANS OF CARE

- ❑ Present a comprehensive treatment plan (including specific drugs) to enhance patient understanding: combined modality CRT followed by consolidation immunotherapy (pending eligibility and lack of disease progression)<sup>3,5,7</sup>
  - » Communicate both the potential benefits and side effects of the treatment plan for patients with Stage III NSCLC<sup>5,17</sup>
- ❑ Provide patients with an intuitive roadmap/timeline with all the treatment appointments booked\*
  - » A nurse, NP, or patient navigator may be in charge of this task\*
- ❑ Confirm that the patient has access to transportation to reach clinics/centers, and coordinate with the nurse, NP, or patient navigator to identify resources to provide logistical assistance, if needed<sup>24,27,28</sup>
- ❑ Encourage patients to engage with nurses/NPs/physician assistants for any additional assistance\*:
  - » Obtaining contact information for MDT members<sup>22</sup>
  - » Coordinating schedules and appointments, including with other specialists<sup>24</sup>
  - » Bridging across potential cultural and communication barriers<sup>24</sup>
  - » Discussing financial toxicity associated with cancer treatment and programs/resources to help alleviate financial burden<sup>29-31</sup>

### NOTES

## 6 INITIATION AND CONTINUATION OF CHEMOTHERAPY



Schedule post-cCRT scan during the cCRT treatment period (by week 4) to occur immediately after cCRT and avoid delays in determining disease stabilization or progression\*

- ❑ Emphasize to the patient that it is critical to not miss chemotherapy sessions<sup>32</sup>
- ❑ At each session, relay to the patient how far along they have progressed on their treatment journey (eg, the number of chemotherapy treatments that have been completed and still remain)\*
  - » Reinforce that immunotherapy is a treatment option, if they are eligible based on post-cCRT CT scan results with no evidence of disease progression<sup>5</sup>
- ❑ After initiation of cCRT, see patients frequently to monitor adverse events (AEs); by the third or fourth week, increase the frequency of visits if necessary\*
  - » Telehealth may facilitate patient check-ins\*
  - » Nurses/NPs can also check in with patients\*
- ❑ Adjust chemotherapy treatment plan, in consultation with the radiation oncologist, if necessary<sup>4,33</sup>
  - » Clinical parameters to monitor<sup>4,33\*</sup>:
    - Blood count
    - Kidney function
    - Weight and nutrition
    - Respiratory status
    - General performance status
- ❑ Discuss with the patient whom they should contact if side effects appear\*
  - » Each practice may designate a different MDT member (eg, nurse, NP) who is the primary point of contact<sup>22</sup>
  - » Patients should be able to contact healthcare professionals after hours as well<sup>33</sup>
  - » Proactive AE management may lead to patients completing treatment<sup>4\*</sup>

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## 7 OVERALL STRATEGIES FOR SUCCESSFUL AE MANAGEMENT DURING cCRT

- ❑ Optimize patient health before treatment since cCRT can potentially worsen preexisting conditions<sup>34,35</sup>
- ❑ Proactive management of AEs versus reactive management should be used<sup>34,36\*</sup>
  - » Remain alert for potential toxicities due to chemotherapy: hematologic toxicities (anemia, thrombocytopenia, leukopenia), nausea, and emesis<sup>4</sup>
  - » Check in with the radiation oncologist to determine whether or not the patient has developed radiation esophagitis or pneumonitis<sup>4</sup>
  - » Maintain active communication with the radiation oncology office to assess how the patient is managing side effects<sup>2\*</sup>
    - If a patient cannot tolerate cCRT, chemotherapy may be temporarily suspended, but the patient still has the chance to continue to receive standard-of-care treatment for unresectable Stage III NSCLC\*
- ❑ Pre-authorize and fill medications before treatment so they are available when the patients need them<sup>37</sup>



### Proactive strategies to manage esophagitis:

- ❑ Prepare a toolbox to help patients proactively manage esophagitis symptoms\*
  - » Antacids<sup>26</sup>
  - » Proton-pump inhibitors<sup>26</sup>
  - » Antifungal treatment<sup>34</sup>
  - » Proton pump inhibitors<sup>26</sup>
  - » Nonsteroidal or opioid pain relievers<sup>26</sup>
- ❑ Encourage easy-to-swallow diets, such as smoothies, milkshakes, and nutritional shakes<sup>26</sup>
- ❑ Encourage avoidance of alcohol-based products<sup>38</sup>
- ❑ Encourage hydration by providing bottles with volume demarcations that serve as visual cues for water intake\*
  - » Weight monitoring and IV fluid hydration when needed<sup>26,34</sup>

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## ORDERING SCANS AND SCHEDULING FOLLOW-UP APPOINTMENTS FOR POST-cCRT ASSESSMENT

- ❑ Confirm which office (medical oncologist or radiation oncologist) will perform post-cCRT scan to assess lack of disease progression and confirm candidacy for immunotherapy<sup>2,5\*</sup>
  - » Discuss and confirm timing of post-cCRT scan\*
  - » For eligible patients without disease progression, discuss initiation of immunotherapy within 42 days<sup>3,5,39</sup>
    - Ordering follow-up CT scan during cCRT (preferably by week 4) facilitates timely transition to immunotherapy, pending eligibility based on confirmed lack of disease progression. Perform scans shortly after cCRT completion (ideally within 2 weeks)<sup>5,40</sup>

**[Note: FDG-PET scan is not advised for routine follow-up because higher uptake of <sup>19</sup>F-FDG may occur in response to cCRT-induced inflammation,<sup>41</sup> which could inadvertently be misinterpreted as disease progression even if the disease may have stabilized.\*]**



**The administration of consolidation chemotherapy after cCRT is not recommended because it has not been shown to improve outcomes.<sup>3</sup>**

- ❑ Follow up with radiation oncologist to assess conclusion of radiation treatment plan\*
- ❑ Perform post-cCRT assessment and continue aggressive management of AEs so that immunotherapy can be initiated in a timely manner, pending scan results and patient eligibility<sup>5,24\*</sup>
- ❑ Explain the CT scan results to the patient, and communicate what the next steps are\*
  - » For eligible patients, encourage follow-up consolidation immunotherapy if disease has not progressed<sup>5\*</sup>
  - » Suggest another treatment option if disease has progressed\*
    - Discuss next treatment options with other members of the MDT (ie, radiation oncologist)

NOTES

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