



# The role of MDTs in optimizing NSCLC management: From early disease and beyond



An expert panel discussion recorded in October 2020

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# Expert panel



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# Agenda

## **How can MDTs work together to provide optimal care for patients with NSCLC?**

*Presentation: Solange Peters*

*Panel discussion: Walter Weder, Françoise Mornex, Albrecht Stenzinger*

## **What does successful MDT communication involve?**

*Presentation: Solange Peters*

*Panel discussion: Walter Weder, Françoise Mornex, Albrecht Stenzinger*

## **What strategies are needed to overcome barriers to implementing MDT decisions and improve uptake of research?**

*Presentation: Solange Peters*

*Panel discussion: Walter Weder, Françoise Mornex, Albrecht Stenzinger*

# How can MDTs work together to provide optimal care for patients with NSCLC?

## **Prof. Solange Peters**

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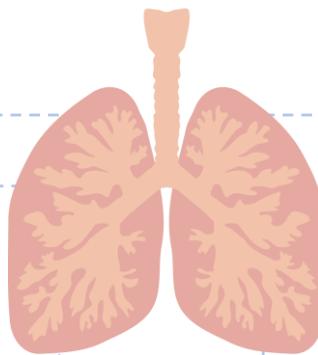


# The role of the MDT is critical in NSCLC management

Lung cancer is the leading cause of cancer-related death worldwide<sup>1</sup>

The MDT has a crucial role in clinical staging and proposing primary treatment<sup>2,3</sup>

MDTs are more efficient at managing patients with lung cancer by providing more complete staging, better adherence to guidelines and increased survival<sup>3-5</sup>



Accurate clinical staging determines the best treatment strategy for the individual patient<sup>2</sup>

Accurate diagnosis and staging are particularly important in stage III patients; influences the possibility of allocation to curative-intent treatment<sup>2</sup>

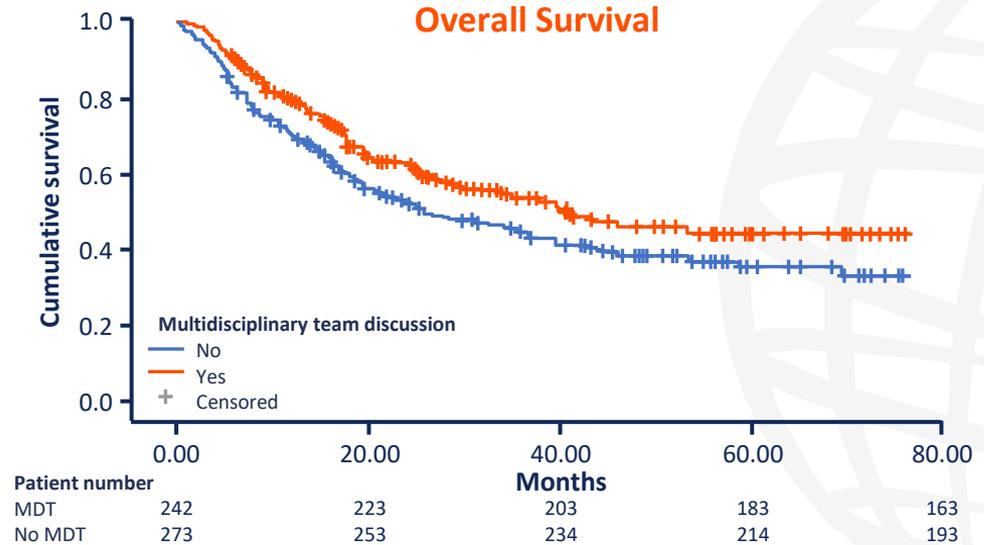
MDT recommendations are important since guidelines may not be able to cover each individual clinical situation as well as new clinical data<sup>6</sup>

MDT, multidisciplinary team; NSCLC, non-small cell lung cancer.

1. World Health Organization. Fact sheet cancer. 2018. [who.int/news-room/fact-sheets/detail/cancer](https://www.who.int/news-room/fact-sheets/detail/cancer) (accessed 19 October 2020); 2. Hoeijmakers F, et al. *Chest*. 2020;S0012-3692(20)32079-1. 3. Planchard D, et al. *Ann Oncol*. 2018;29(Suppl 4):iv192-237. 4. Freeman RK, et al. *Eur J Cardiothorac Surg*. 2010;38:1-5. 5. Forrest LM, et al. *Br J Cancer*. 2005;93:977-8. 6. Soukup T, et al. *J Multidiscip Healthc*. 2018;11:49-61.

# MDT discussion results in survival benefit for patients with stage III NSCLC

- Treatment for stage III NSCLC often involves multi-modality treatment and can vary widely from patient-to-patient
- Retrospective study aimed to evaluate whether MDT discussion results in better patient survival (n=515)
- Median survival of all patients was 33.9 months
- Median survival of patients treated after MDT discussion was 41.2 months and that of patients treated without MDT discussion was 25.7 months ( $p=0.018$ )



Survival curve of patients with stage III NSCLC according to whether MDT discussion was performed

# Variation in treatment options will continue to expand with new clinical trial data

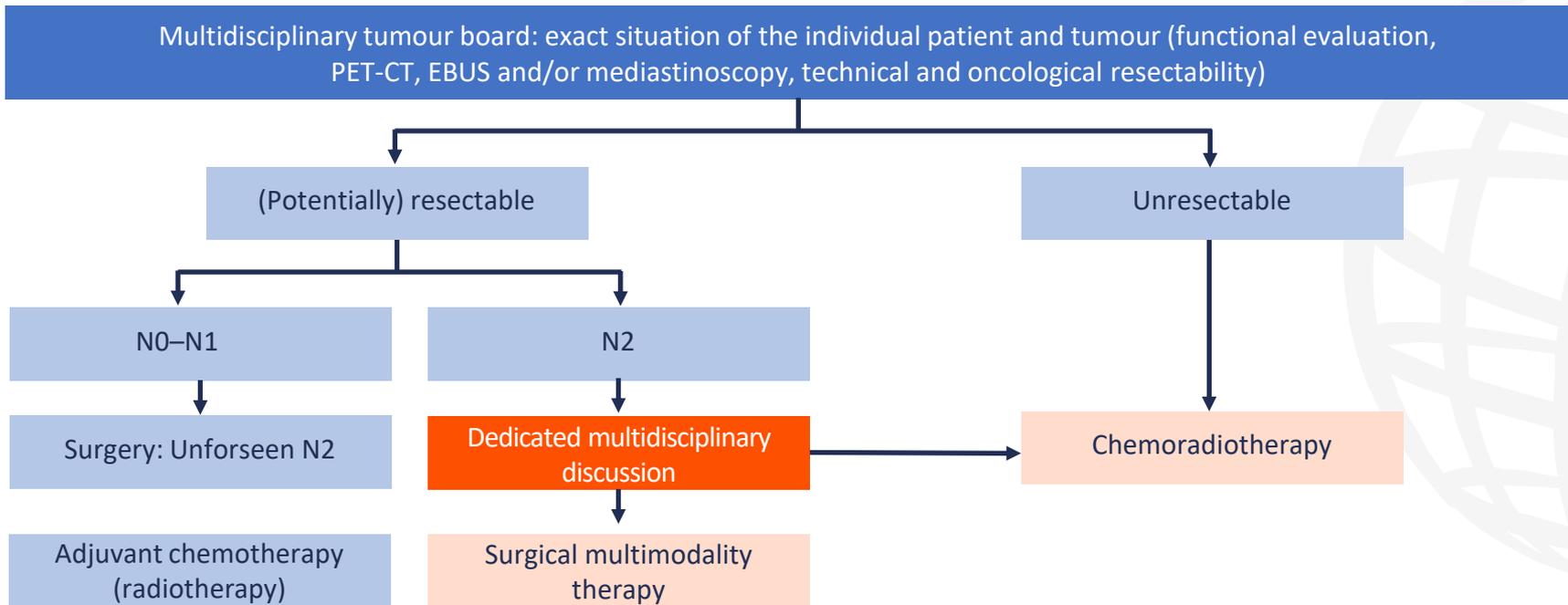
- Variation in treatment will increase because of the results of the **PACIFIC** trial, which showed prolonged survival with adjuvant durvalumab after CRT for unresectable stage III NSCLC<sup>1</sup>
- Updated OS data from **PACIFIC**, including 3-year survival rates, further establish this regimen as the standard of care after CRT in this population<sup>2</sup>
- In the **ADAURA** trial, patients with completely resected *EGFR*-mutation positive NSCLC (stage IB to IIIA) had significantly longer DFS among those who received osimertinib vs placebo<sup>3</sup>
- The FDA has granted adjuvant osimertinib BTB status in early-stage *EGFR*-mutant NSCLC following complete resection
- The role of PORT has been the subject of debate in patients with mediastinal nodal involvement
- The **Lung ART** study did not show a statistically significant difference in 3-year DFS in patients with NSCLC following complete resection and after (neo)adjuvant chemotherapy<sup>4</sup>

BTB, breakthrough therapy designation; CRT, chemoradiotherapy; DFS, disease-free survival; EGFR, epidermal growth factor receptor; FDA, US Food and Drug Administration; NSCLC, non-small cell lung cancer; OS, overall survival; PORT, post-operative radiotherapy.

1. Antonia SJ, et al. *N Engl J Med*. 2018;379:2342–50. 2. Gray JE, et al. *J Thorac Oncol*. 2020;15:288–93; 3. Wu Y-L, et al. *N Engl J Med*. 2020;383:1711–23; 4. Le Pechoux C, et al. *Ann Oncol*. 2020;31(Suppl. 4):S1178 (Abstr. LBA3\_PR).

# Standard of care in current guidelines

## NSCLC stage III



# What does successful MDT communication involve?

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# Increasing evidence that timing of the MDT should be considered a medical intervention in its own right

The lung cancer MDT has an important prognostic role<sup>1</sup>

- Single-centre, post-hoc analysis of institutional registry data



Data collected prospectively between Jan 2006–Dec 2012



All patients had tissue diagnosis of lung cancer



Patients presented in MDT  
n=295



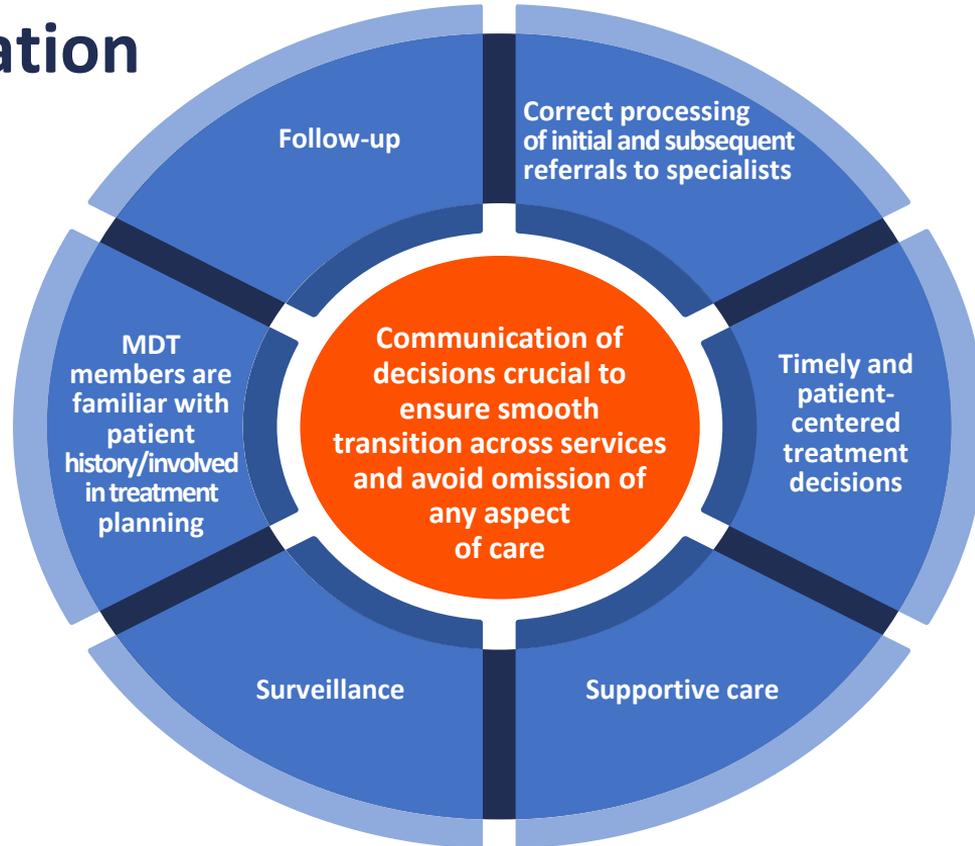
Patients not presented in MDT  
n=902

Patients discussed in the MDT were younger and more likely to have early-stage disease<sup>2</sup>

Unadjusted 1-, 2- and 5-year survival probability was higher in the MDT group for all stages of NSCLC<sup>2</sup>

Multivariate analysis showed 5-year OS was significantly better in the MDT group (HR: 0.7 [95% CI: 0.58–0.85])<sup>2</sup>

# Key to the process of MDT management is effective communication



# Characteristics for effective MDT working in cancer



- Level of expertise and specialization
- Attendance of MDMs
- Leadership
- Team working and culture (e.g., mutual respect and trust)
- Personal development and training

- Appropriate meeting room
- Availability of technology and equipment

- Preparation for and organization of regular meetings
- Post-meeting coordination services for the patient

- Who to discuss, i.e., having local mechanisms in place to identify all patients where discussion at MDM is needed
- Patient-centered care (e.g., patient's views and preferences are presented by informed HCP)
- Clinical decision-making process is based on all relevant information and available evidence

- Organizational support (e.g., funding and resources)
- Data collection during team meetings, analysis and audit of outcomes (e.g., patient experience surveys)
- Clinical governance (e.g., there are agreed policies, guidelines, and protocols for MDTs)



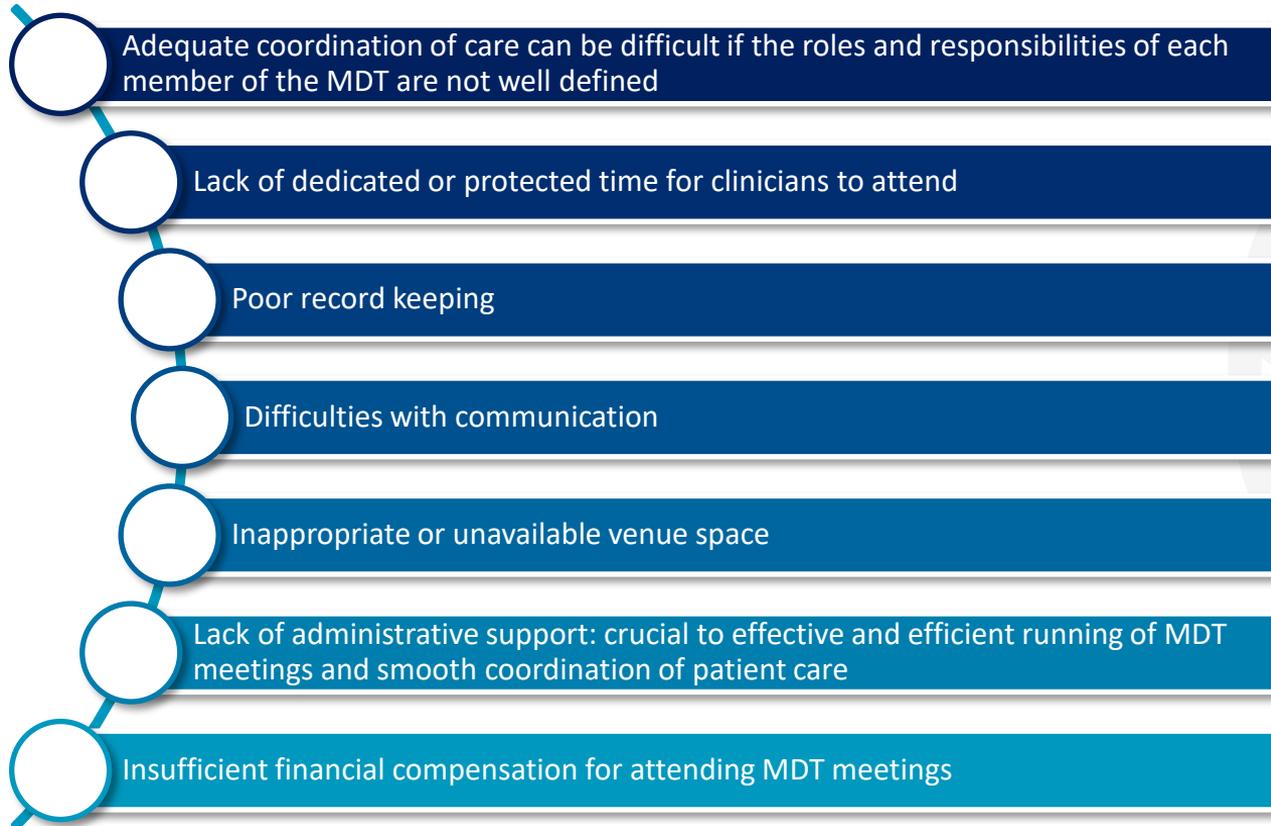
# What strategies are needed to overcome barriers to implementing MDT decisions and improve uptake of research?

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# Multiple barriers exist to successful MDT care



MDT, multidisciplinary team.

1. Denton E, Conron M. *J Multidiscip Healthc.* 2016;9:137-44.

# NSCLC management in the COVID-19 era: The value of shifting consultations to telemedicine

## Outpatient visit priorities

High priority	Medium priority	Low priority
New diagnosis or suspicion of invasive lung cancer with either: <ul style="list-style-type: none"> <li>• Disease-related symptoms (dyspnoea, pain, haemoptysis, etc.)</li> <li>• Suspicion of clinical stage III or metastatic NSCLC or SCLC</li> </ul>	New diagnosis or suspicion of localized lung cancer (stage I)	Patient visits for psychological support (convert to telemedicine)
		Survivorship visits
	Follow-up for patients at high-risk of relapse	Follow-up for patients at low/intermediate risk of relapse
Outpatient visits for treatment administration	Established patients with new problems or symptoms from treatment – convert as many visits as possible to telemedicine visits	Postoperative patients with no complications – convert as many visits as possible to telemedicine visits