



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?

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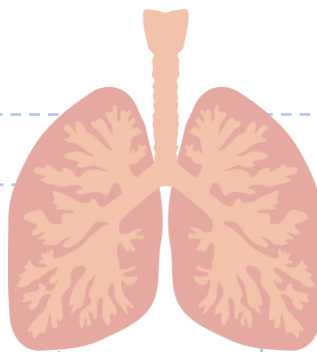


The role of the MDT is critical in NSCLC management

Lung cancer is the leading cause of cancer-related death worldwide¹

The MDT has a crucial role in clinical staging and proposing primary treatment^{2,3}

MDTs are more efficient at managing patients with lung cancer by providing more complete staging, better adherence to guidelines and increased survival³⁻⁵



Accurate clinical staging determines the best treatment strategy for the individual patient²

Accurate diagnosis and staging are particularly important in stage III patients; influences the possibility of allocation to curative-intent treatment²

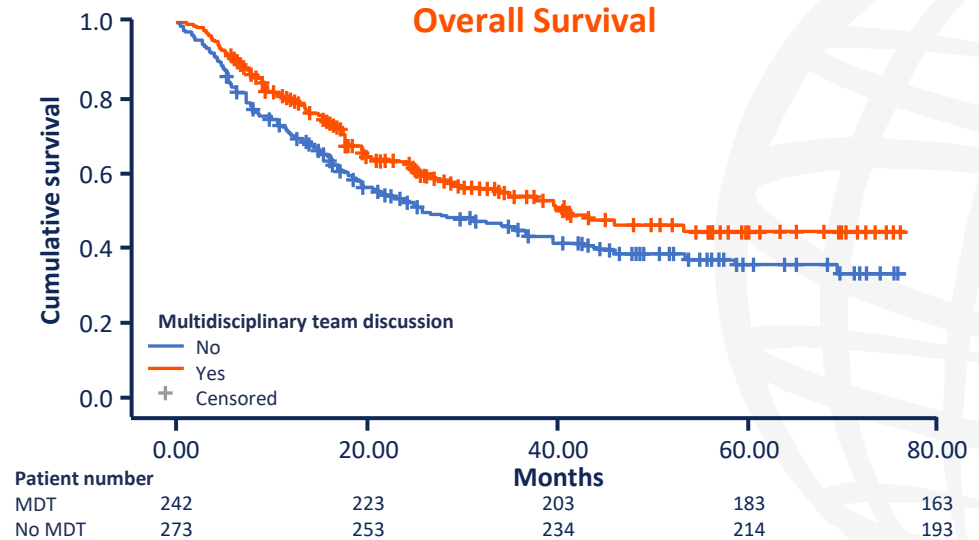
MDT recommendations are important since guidelines may not be able to cover each individual clinical situation as well as new clinical data⁶

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 NSCLC¹
- Updated OS data from **PACIFIC**, including 3-year survival rates, further establish this regimen as the standard of care after CRT in this population²
- 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 placebo³
- 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 chemotherapy⁴

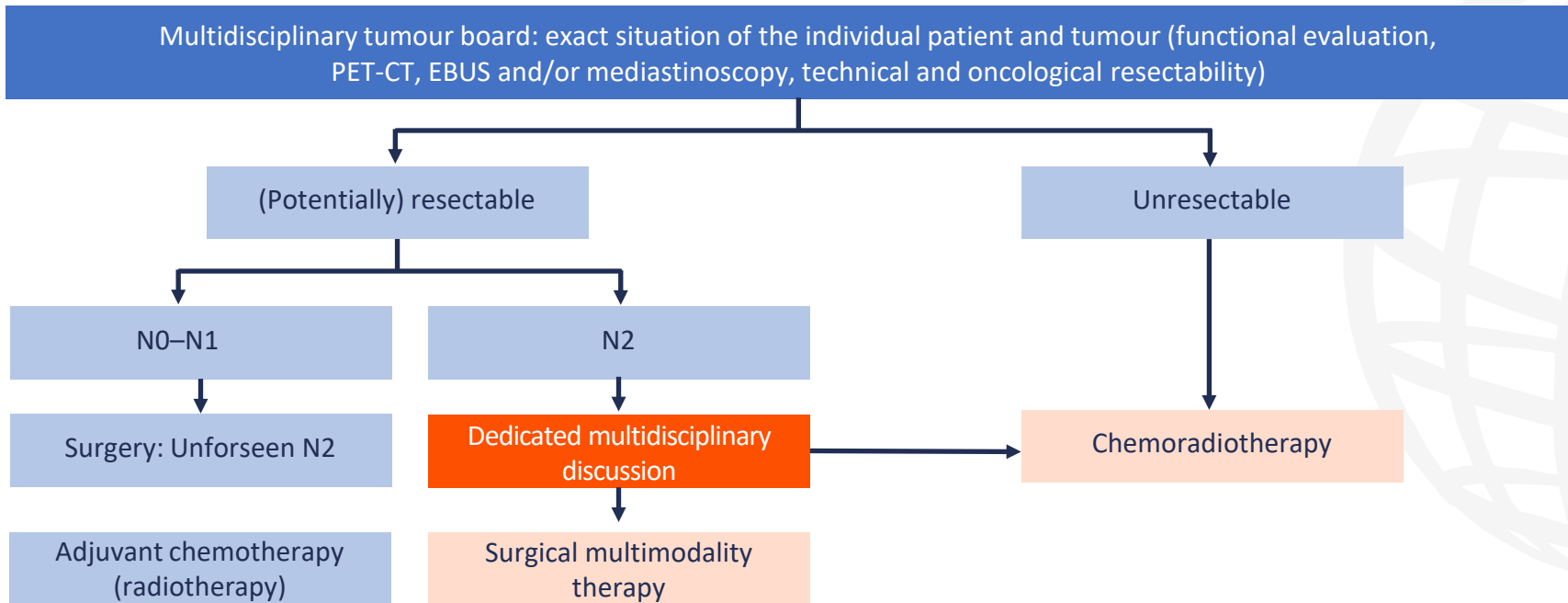
BTB, breakthrough therapy designation; CRT, chemoradiotherapy; DFS, disease-free survival; EGFR, epidermal growth factor receptor; FDA, US Food and Drug Administration; NSCLC, non-small cell lung cancer; OS, overall survival; PORT, post-operative radiotherapy.

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 role¹

- 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



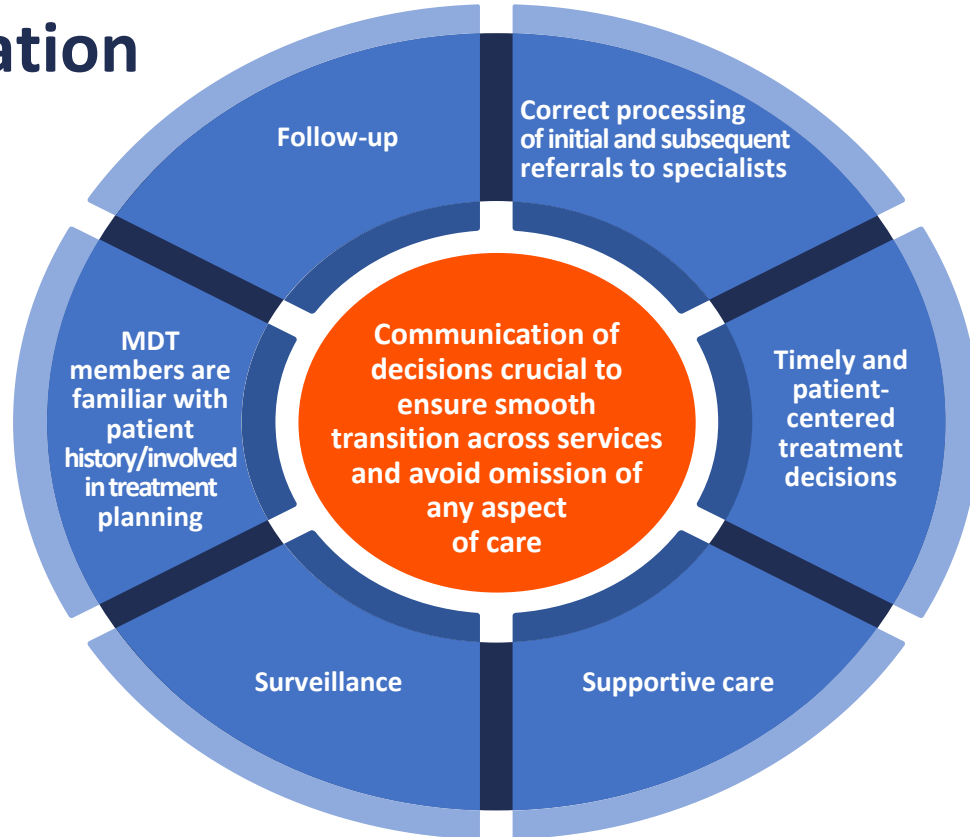
Patients not presented in MDT
n=902

Patients discussed in the MDT were younger and more likely to have early-stage disease²

Unadjusted 1-, 2- and 5-year survival probability was higher in the MDT group for all stages of NSCLC²

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

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"> • Disease-related symptoms (dyspnoea, pain, haemoptysis, etc.) • Suspicion of clinical stage III or metastatic NSCLC or SCLC 	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