

Transcript Details

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From Evidence to Practice: Advances in Malignant Pleural Effusion Management

Announcer:

This is *Clinician's Roundtable* on ReachMD. On this episode, we'll hear from Dr. Nicholas Pastis, Director of Interventional Pulmonology and Professor of Medicine at The Ohio State University Wexner Medical Center. He'll be sharing how landmark trials in malignant pleural effusion have impacted patient care. Here's Dr. Pastis now.

Dr. Pastis:

There's been four or five landmark trials over the last decade—randomized controlled trials, robust design, multicenter. I think the overarching theme that we're seeing is that with the tunneled pleural catheter, which is a nice option to manage malignant pleural effusions, patients can go home with it and manage it at home without a lot of hospital trips. It avoids a lot of emergency visits. It keeps the fluid drained. It has an opportunity to pleurodesis, or seal off the lungs, and it can even come out. It was at one time relegated to patients who just had entrapped lung, whereas the more invasive techniques were used first choice. Now, a tunneled pleural catheter is an option in almost all cases of malignant pleural effusion, with the decision being made based on patient characteristics.

I'd start out with the AMPLE trial. It showed initially that with one of the standard treatments—patients come in the hospital, get a chest tube, sit there for four days or longer, get drained, and then get a chemical pleurodesis to try to seal off the lung—they compared that strategy to the tunneled pleural catheter, and really the symptom control was the same, but the tunneled pleural catheter seemed to reduce hospital stay and subsequent procedures. So that lit a little bit of a flame showing that could be considered early on.

Then we got into a couple of other trials regarding how frequently to drain the tunneled pleural catheter and give it a better chance to lead to auto pleurodesis, sealing off the two linings around the lung, the visceral and parietal pleura. The first study was the AMPLE-2 trial, a very big, well-done multicenter trial showing that daily drainage at home with that catheter was better than if somebody just said, "Oh, I'm feeling short of breath, and now I'm going to drain it," and we really didn't know which was better. And the daily drainage led to a better rate of auto pleurodesis.

And then that got fine-tuned a little further with the ASAP trial led out of Duke University, and that was actually comparing every other, so a little more regimented with than just as needed with daily drainage. And the daily drainage really had a significant improvement in sealing off the lungs and getting the catheter out. None of those were 100 percent, but you're approaching 50 percent or so of the time you can get the catheter out, which is a benefit to those patients.

So then you have another trial, another big randomized controlled trial in the UK, called the TAPPS trial. And that looked at chest tube pleurodesis and thorascopic talc poudrage at three months, and it was the most robust trial to show that you really could do chest tube pleurodesis, and using the insufflation through the thoracoscope didn't improve pleurodesis. It did not have a better pleurodesis rate than chest tube pleurodesis. So both are acceptable. Talc through the thoracoscope has advantages though. You're able to take biopsies, a little more information can be gained, and you can even put a tunneled pleural catheter with that.

And that leads us to the TACTIC trial, which is the most recent of these landmark trials in 2026. And that looked at thoracoscopy with talc insufflation versus a combination of talc with thoracoscopy, and then adding the tunneled pleural catheter. It didn't really shorten the index hospitalization, but it did reduce the need for repeat procedures to a significant degree. So by adding that little addition to the procedure of the tunneled pleural catheter, drying the space with that, and then leaving it in and trying to get it out as soon as possible, the need for repeat procedures was significantly reduced. I think it was 34 percent for repeat procedures without the tunneled catheter and only 3 percent in that study if you had the tunneled pleural catheter. So I think depending on the patient, you have several options with tunneled pleural catheter at the forefront.

Announcer:

That was Dr. Nicholas Pastis discussing advances in the management of malignant pleural effusion. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!