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Communicating Pathologic Response Results in Resectable NSCLC

Announcer:
You're listening to *Project Oncology* on ReachMD, and this episode is sponsored by Bristol Myers Squibb. Here's your host, Dr. Charles Turck.

Dr. Turck:
This is *Project Oncology* on ReachMD, and I'm Dr. Charles Turck. Joining me to share their insights on how pathologic response results are communicated to patients with non-small cell lung cancer are Drs. Alexander Spira and Robert Merritt. Dr. Spira is the Director of the Thoracic and Phase 1 Programs at Virginia Cancer Specialists Research Institute and a Clinical Assistant Professor at Johns Hopkins. Dr. Spira, welcome to the program.

Dr. Spira:
Hi, thank you for having me. It's great to be here today.

Dr. Turck:
And not only is Dr. Merritt a Professor and the Director of the Division of Thoracic Surgery at Ohio State University, but he's also the Director of Inpatient Services at The James Cancer Hospital. Dr. Merritt, thanks for being here today.

Dr. Merritt:
Thanks for having me.

Dr. Turck:
So why don't we begin our conversation with you, Dr. Merritt. In the immediate post-operative setting, how do you explain pathologic response findings to patients in a way that's clear and understandable?

Dr. Merritt:
So I start by setting expectations, and I explain that the pathology report is our best snapshot of what we removed during surgery and what the important components are, including margins and lymph node status.

Next, I like to translate the key terms into plain language. For example, a pathologic complete response means that there are no living cells seen in the specimen, and residual disease means we can still see cancer cells. I try to explain that in relative terms and what it means in terms of prognosis and what the next steps are in terms of treatment.

And I like to close the conversation by explaining to patients that I will review this with their medical oncologist, and we will work together to figure out the next steps in terms of additional treatment or surveillance.

Dr. Turck:
And once those findings have been discussed, Dr. Spira, how do you build on the surgeon's conversation and help patients understand what their results mean for next steps in care?

Dr. Spira:
Yeah. So this is a very complicated area for sure, and I'm going to operate under the assumption right now that these are patients that receive neoadjuvant therapy. There's obviously a big push towards preoperative therapy with both chemotherapy and immunotherapy. Some patients may not have gotten that, either because we thought they were lower stage to begin with and they're higher stage now, there was a question, or they just didn't get it. Despite the fact we know that neoadjuvant chemoimmunotherapy does improve outcomes, it still doesn't happen in everyone for various reasons, some of which are very legitimate medically.

But if we look at those patients who have gotten preoperative therapy, it's a really tough question right now, and there are three things: you could have a good response, complete response, or no response. And there's still a lot of uncertainty. There's been a lot of studies and a lot of debate in the literature and at conferences as to what to do in that scenario, and we're still not a hundred percent sure that if you got a complete response, is more immunotherapy better? If you didn't get a complete response, should we be treating more? And those studies may happen in the future, but we don't know. So I think it's really important to discuss with our patients at that point what we know, what we don't know, and then have that joint decision-making. In fact, I like to do this before surgery so there are no surprises after. And there is still a huge debate, and there'll be an ongoing debate in the literature and amongst physicians until we really know for sure.

What I do tell them is that the better response that we get, the better you are able to do. So those that have a complete pathologic response will do better for the long term. And I think that's important to discuss because you do want to manage expectations should the malignancy return and have them know what the appropriate follow-up is.

Dr. Turck:
Let's come back to you, Dr. Merritt. When you're reviewing pathology reports after resection, which findings are most important for you to highlight when discussing results with patients?

Dr. Merritt:
In the era of immunotherapy given before surgery, I think this conversation is very complex. So it's important to focus on the important elements of the pathology report and what it means for patients individually. So first, I focus on the big-ticket items—things that really drive the prognosis and determine the next steps for the patient. So in my mind, the big-ticket items are surgical margins, lymph nodes, and how much viable tumor is present after neoadjuvant immunotherapy. I explain to patients that the margins simply mean, did we remove all of the cancer? And are all of the surrounding areas around the tumor clear of cancer?

Next is the nodal status. I explain how many nodes I removed and if any of those nodes had any tumor within them because that has implications on staging and additional treatment after surgery. In the era of immunotherapy, pathologic response is important. So I explain if they had a complete response, partial response, or no response because again, that does have implications for where next steps may be. And I try to explain this in very simple terms so that they can understand.

Also, I go over the stage: is this stage one, two, three, or four? And that certainly has implications for prognosis and treatment. And if there are any surprises or anything that we didn't anticipate, such as positive margins or positive nodes, I really try to explain this in terms that they can understand and how it dictates our next steps.

Dr. Turck:
For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Drs. Alexander Spira and Robert Merritt about how surgeons and oncologists can collaborate to communicate treatment response and guide next steps in non-small cell lung cancer.

Now, Dr. Spira, when multiple specialists are involved, consistency in messaging is critical. What strategies do you use to ensure alignment across disciplines so that patients receive a clear and unified understanding of their results?

Dr. Spira:
I think this is really important pre-surgery because this is where it gets complicated. Patients are anxious. They have a newly diagnosed cancer. They're presented at tumor boards, and admittedly, there's a lot of different options you can do, especially in what I call the locally advanced setting—it's what we would typically call IIIA or borderline IIIB non-small cell lung cancer—and that's because some of these patients are resectable and some of these patients are not resectable, but there's a large gray zone as to whether or not they are resectable or not.

Furthermore, it's also important because these patients may need further preoperative staging, like looking at lymph nodes, etc., because that may change how we approach things, like whether or not a patient gets preoperative therapy. I've had patients, and I'm sure Bob has had this as well, where somebody walks in who didn't even have a biopsy, and you're looking at somebody and it looks like it's early stage. Do you just take the patient to surgery and you get a diagnostic-therapeutic approach? And while we like to give patients preoperative therapy, sometimes biopsies aren't easy. Sometimes the surgeon will say, "It's a chip shot for me to take it out," and we'll figure it out on the backend.

So it's very important that the patient either goes to a multidisciplinary clinic. Some institutions have that; we do not. We have tumor boards where all our patients are discussed, and it's important that there be one unified message. Patients don't want to hear, "You could do A, or you could do B," and hear any disagreement among their physicians. These are not necessarily easy questions, but I

think there needs to be one uniform message that the patient hears from everybody, and that can be done, right? There may be multiple approaches, but in the end, the patient wants to hear one best approach, of course, with the patient conceding and listening to that and understanding that. So having these discussions and avoiding misinterpretations is incredibly important so the patient feels comfortable in their decision when it's not necessarily black or white but certainly a lot of gray right now.

Dr. Turck:
Turning back to you, Dr. Merritt, would you share an example of how you frame findings around pathologic response to help set a patient's expectations?

Dr. Merritt:
I explain essentially the options. One, if there is a pathologic complete response, this is very encouraging. I communicate to the patients that in the tumor that we removed, the pathologist didn't see any viable tumor cells. This tells us that the preoperative treatment, which is typically neoadjuvant immunotherapy, worked the way that we hoped it would. And then I explain what this means in terms of follow-up with their oncologist.

The other option if there is residual disease in the pathologic specimen, the treatment did work but it didn't work completely. And it's important to communicate to the patients that this is not a failure of the treatment; it's just a spectrum of responses that we often see with neoadjuvant immunotherapy. So it doesn't have any negative implications on their prognosis or outcome. It's just a pathologic observation that we saw.

And then I frame with the patient that the next course of action is to see your medical oncologist and discuss any additional treatments that may be needed after surgery. So it's very important to explain what this pathologic response means in terms that patients can understand and not to assume that it's a failure if they don't have a complete pathologic response.

Dr. Turck:
Finally, Dr. Spira, as you guide patients through next steps, how do you discuss treatment planning while also addressing the emotional impact of these results?

Dr. Spira:
A really good question for a couple of reasons. One is once a patient receives preoperative therapy and they've had surgery, they want to be done, right? I mean, let's face it, patients want to move on with their lives, and that's a very important concept. Nobody wants to do more therapy, both physically and emotionally.

I also discuss with them what's unknown. There's a huge amount of what's unknown here for our patients in terms of what to expect and whether or not the treatment actually does improve outcomes postoperatively. So I do review that with them. I try and get them to understand that upfront.

And with that in mind, I then come up with a recommendation, allow them to ask questions, and work with them. There may be some patients that you really want to give further therapy to, but the patient is done. They may have had a longer recovery from surgery than we would like. So what I usually tell them at that point is what I recommend, but I work with them at that time and be very open. We always underestimate what's going on with our patients—not only the physical part of cancer, but the emotional part as well.

Dr. Turck:
As those final comments bring us to the end of today's program, I want to thank my guests, Drs. Alexander Spira and Robert Merritt, for joining me to discuss how pathologic response results are communicated to patients with non-small cell lung cancer following surgery. Dr. Spira, Dr. Merritt, it was great having you both on the program.

Dr. Spira:
Thanks for having us today.

Dr. Merritt:
Thank you.

Announcer:
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