Transcript Details
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Expanding Molecular Testing in Community NSCLC Care

Announcer:
You're listening to *Project Oncology* on ReachMD. On this episode, we'll hear from Dr. Apar Kishor Ganti, who's the Doctor and Mrs. D. Leon UNMC Research Fund Chair in Internal Medicine at the University of Nebraska Medical Center. He is a Staff Physician at the VA Nebraska Western Iowa Health Care System, Professor of Medicine in the Division of Oncology-Hematology, and Professor of Biochemistry and Molecular Biology at the University of Nebraska Medical Center. He'll be discussing the importance of molecular testing for non-small cell lung cancer in community settings.

Here's Dr. Ganti now.

Dr. Ganti:
When we talk about molecular testing in non-small cell lung cancer, there are significant barriers, especially for small community practices. The first thing that comes to mind is the adequacy of the specimen. For example, to get adequate NGS testing done, we need to have a specific number of cancer cells in the specimen. So, if you have a small biopsy specimen, most of the tissue may have been exhausted in making the diagnosis, and as a result, not enough cells are remaining for NGS testing.

The second barrier is logistical. So, if there has been a biopsy done in one particular hospital, and the medical oncologist is in a separate office, getting the specimen from the hospital or the pathologist over to the medical oncology office and subsequently to the lab that does the NGS testing can take up to two weeks. And then, subsequently, once the specimen gets to the lab for the testing, that takes another two to three weeks for the actual test to be done.

And the third major challenge is insurance rules that state that once a patient has been discharged from the hospital, any test that is done within 14 days will not be paid for and will be considered part of the hospitalization. This can be a significant challenge.

Given the challenges with trying to obtain NGS testing or molecular testing in patients with non-small cell lung cancer, different groups have looked at various practical tools or strategies in order to hasten the testing and decrease the delay in starting treatment. One of these would be to use a liquid biopsy, which often can get results within about five days. Since blood samples can be collected from the patients at any time, the challenges that we see in obtaining the tissue and sending the tissue to the lab can be significantly decreased. A lot of companies that have been the liquid test will also have phlebotomy services go to the patient's house to get the samples. So, that can be a significant benefit for patients who may have to drive distances to get to the hospital or to the oncology office.

The other approach that certain other practices have tried is what we call reflex NGS testing. So, once there is a diagnosis of lung cancer, even before the oncologist orders the NGS, the laboratory will automatically send a specimen to the lab for next-generation sequencing studies.

The other tool that smaller community practices can use is, when the patient is being seen by the oncologist, obtaining the specimen right up front, even before the physician sees the patient and sending that specimen off to the lab. That will help save a few days and, therefore, decrease the time that it takes for the patient to start treatment.

As far as education and care team alignment in expanding molecular testing are concerned, I think they can go a long way. For example, educating the team that does the biopsy—the interventional radiologists or the pulmonologists—on the importance of NGS testing will result in them getting multiple passes or larger tissue biopsies so that we do not have the problem where the sample is insufficient.

Similarly, educating pathologists on the role of NGS testing will result in decreased utilization of the biopsy for immunohistochemistry

stains to make a diagnosis. For example, the International Association for the Study of Lung Cancer recommends just the use of two immunohistochemistry stains—one for adenocarcinoma and one for squamous cell carcinoma—rather than a whole battery of tests just to make a diagnosis of non-small cell lung cancer.

Thirdly, coordination between the pathology office, the medical oncology office, and the lab that does the NGS will be key in order to get those specimens quickly to NGS testing and get the results faster.

Announcer:
That was Dr. Apar Kishor Ganti talking about how we could improve molecular testing for non-small cell lung cancer in community practices. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!