14th World Conference on Lung Cancer
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14TH WORLD CONFERENCE ON LUNG CANCER

3 TEMMUZ 2011

Histology Matters : Personalized Therapy for

Patients with NSCLC

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MEZOTELYOMA TEDAVİS

Multimodality Therapy and MPM

- Surgery Alone
- Surgery and Adjuvant Chemotherapy ± RT
- Intrapleural Chemotherapy and Surgery
- Surgery and Postoperative Radiation
- Neoadjuvant Chemotherapy, Surgery, and Radiation therapy
- Novel Multimodal Schemes
  - Intrapleural Photodynamic Therapy

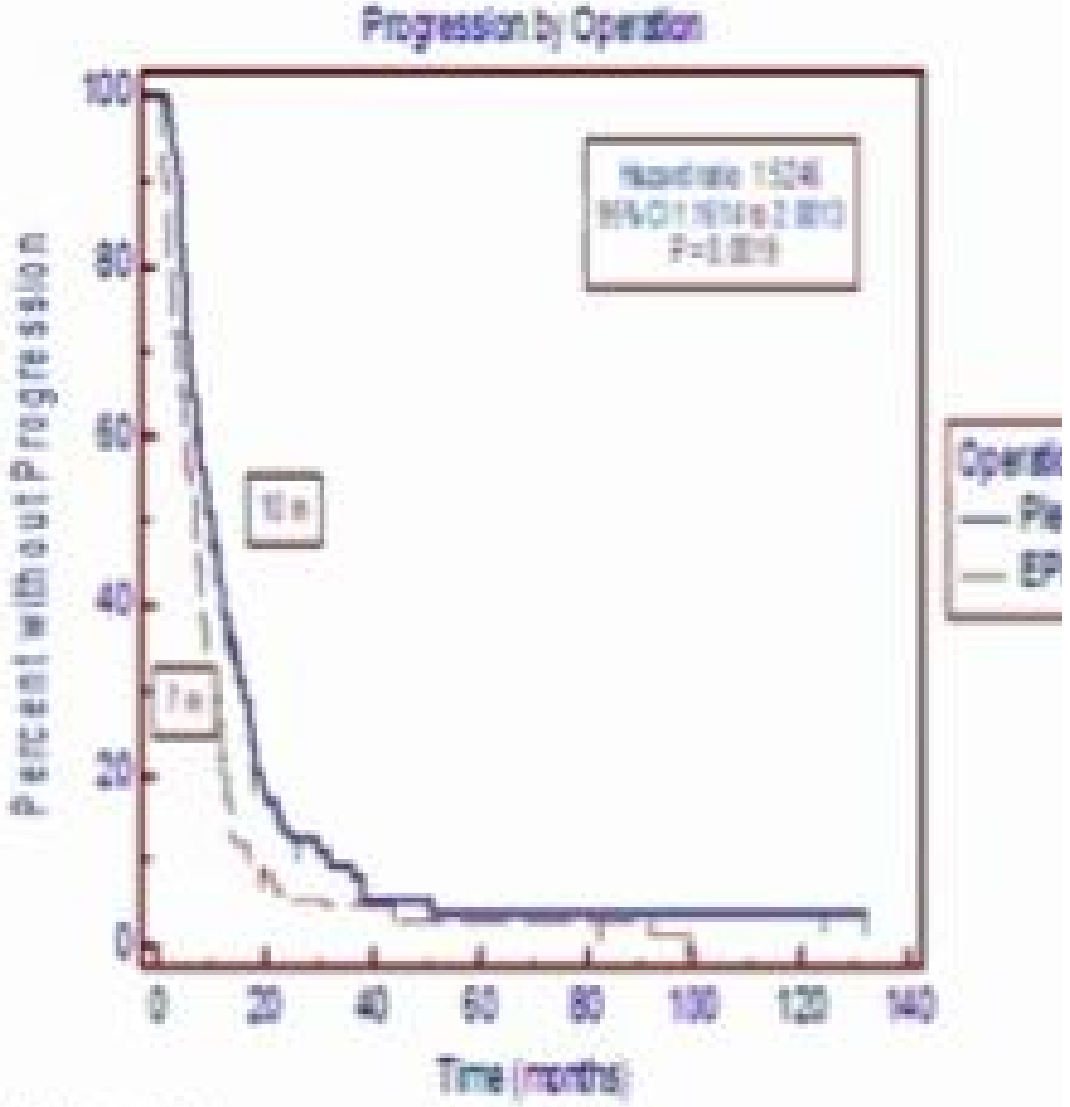
rgery = Maximal Cytoreducti

hat is the *ideal* surgery?

Maybe None? (*I don't think so.....*)

- What about MARS?

If some, then what? And how defined?



sk
rectomy
16 7 0
6 2 0
sy
0 0 0

Number at risk
Group Pleurectomy
96 14 4 2 2 2 2 0
Group EPP
125 9 5 3 3 0 0 0

ariate	b	SE	P	Exp(b)	95% CI of Exp(b)
ne vs. adjuvant therapy	-0.4624	0.08362	<0.0001	0.6298	0.5350 to 0.7413
er or epithelial	0.2284	0.1091	0.0362	1.2566	1.0159 to 1.5544
le or Female	0.3712	0.1767	0.0357	1.4494	1.0269 to 2.0458
or P	0.2661	0.1511	0.0782	1.3049	0.9719 to 1.7521
e or early stage	0.9087	0.1261	<0.0001	2.4812	1.9402 to 3.17

Cox Proportional Hazards Model for Risk of Recurrence

ariate	b	SE	P	Exp(b)	95% CI of Exp(b)
e vs. adjuvant therapy	-0.2962	0.08731	0.0007	0.7437	0.6272 to 0.8817
r or epithelial	0.1755	0.1127	0.1194	1.1918	0.9567 to 1.4846
or Female	0.3602	0.1763	0.0410	1.4336	1.0166 to 2.0215
or P	0.06881	0.1507	0.6479	1.0712	0.7985 to 1.4371
or early stage	0.7116	0.1222	<0.0001	2.0372	1.6052 to 2.5855

SINIRDA HASTADA AMELİYAT

Clinical case: high risk patient

- 61-y-o male. Retired welder
- Ex-smoker of 1 p/d till 20 years ago
- Chronic expectoration & dyspnea on exertio
- Present disease: Bloody expectoration x 6 months
- PE: irrelevant for the case

CT of the chest at diagnosis

Size:
32 x 40 x 3

Mediastin
norma

- Blood analyses & EKG: normal
- PFT: FVC 2440 (80%), FEV1 1420 (63%
  FEV1/FVC 58%; DLCO 59%; KCO 80%
- Walking test: Initial Sat O2: 93%; final:
  92%; 473 metres
- PET: abnormal uptake in mass, SUVmax
- Perfusion lung scan: R: 65%; L: 35%
- Post-pneumonect. predicted FEV1: 923

TNM staging system for thymic epithelial tumors

artment of Oncological Medical Services, Institute
lth Biosciences,
University of Tokushima Graduate School, Japan

uya Kondo

System (1979)

ge I

ntact capsule or growth within the
apsule

ge II

Pericapsular growth into the mediastinal
at tissue or adjacent pleura or
pericardium

ge III

nvasive growth into the surrounding

Masaoka Staging System(1981

Macroscopically encapsulated tumor, with
no microscopic capsular invasion

Macroscopic invasion into surrounding fa
tissue or mediastinal pleura

Microscopic invasion into the capsule

Macroscopic invasion into neighboring o

Pleural or pericardial metastases

Lymphogenous or hematogenous metasta

Koga Staging System (1994)

Grossly and microscopically completely
encapsulated tumor

Microscopic transcapsular invasion

Macroscopic invasion into thymic or
surrounding fatty tissue, or grossly adherent
to **but not breaking through mediastinal**
pleura or pericardium

Macroscopic invasion into neighboring organ
(i.e. pericardium, great vessel or lung)

Pleural or pericardial metastases

miques) Staging System of Thymomas (

e Ia Encapsulated tumor, **totally resected**

-b Macroscopically encapsulated tumor, **totally resected**, but the surgeon suspect mediastinal adhesions and potential capsular invasion

e II Invasive tumor, **totally resected**

e IIIa Invasive tumor, **subtotally resected**

-b Invasive tumor, **biopsy**

e IVa Supraclavicular metastasis or distant

roscopically completely encapsulated and inv

capsular invasion

croscopically adhesion or invasion into surroun

sue or mediastinal pleura, or microscopic invasi

osule

asion into neighboring organ, such as pericardi

sels, and lung

ural or pericardial dissemination

lymph node metastasis

etastasis to anterior mediastinal lymph nodes

etastasis to intrathoracic lymph nodes except an

ediastinal lymph nodes

etastasis to extrathoracic lymph nodes

a homatogenous metastasis

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SURGERY: STAGING

Discussion

Valerie W. Rusch, M.D.
Chief, Thoracic Surgery Service
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New York, New York

nparison of diagnostic yield of endoscopic ultrasoun ing of Non-Small Cell Lung Cancer (NSCLC) perform ith use of Endobronchial Ultrasound (EBUS) and/or esophageal Ultrasound (EUS) with invasive staging SCLC performed with use of Transcervical Extended Mediastinal Lymphadenectomy (TEMLA)

Marcin Zieliński, Juliusz Pankowski, Tomasz Nabiałek, Artur Szlubowski

PULMONARY HOSPITAL
ZAKOPANE, POLAND

astalara (n=540), ameliyat öncesi EBUS+EUS

yor.

rdından hemen hemen tamamına TEMLA yapıl

onuç: EBUS + EUS ile TEMLA arasında LN(-)

larda tanısal değer açısından fark yok

Mediastinoscopy after (-) EBUS

Tournoy et al. (abstract 003.02, p282)

mines subset of patients in ASTER trial (n=1

BUS +/- EUS + CME more sensitive than CME alone
pts needed CME in order to detect 1 N2/N3 LN not
EBUS)

was to identify pts in whom CME could be
ted

6 pts with LN <10mm by CT, CME did not imp
ensitivity and NPV of EBUS (89%, 93%)

Prospective trial of EBUS vs. iastinoscopy (CME) for staging NS

Yasufuku et al. (Toronto)

- Presented at 2011 AATS meeting
- Currently under review at JThCvS
- Findings show that systematically performed EBUS – TBNA (at multiple lev as good as CME for pre-resection staging

[illegible]

MEMS: Micro-electronic mechanical

ems

Interventions to improve LN collection and pathologic examinaton during NSCLC resectio

Osarogiagbon et al. (abstract 003.03, p283)

dresses standardization of surgical and pathol actices

arm case control study:

"routine" surgical LN collection + path exam (arm 1)

"routine" surgical LN collection + "special" path exam

"special surgical LN collection + "special" path exam (

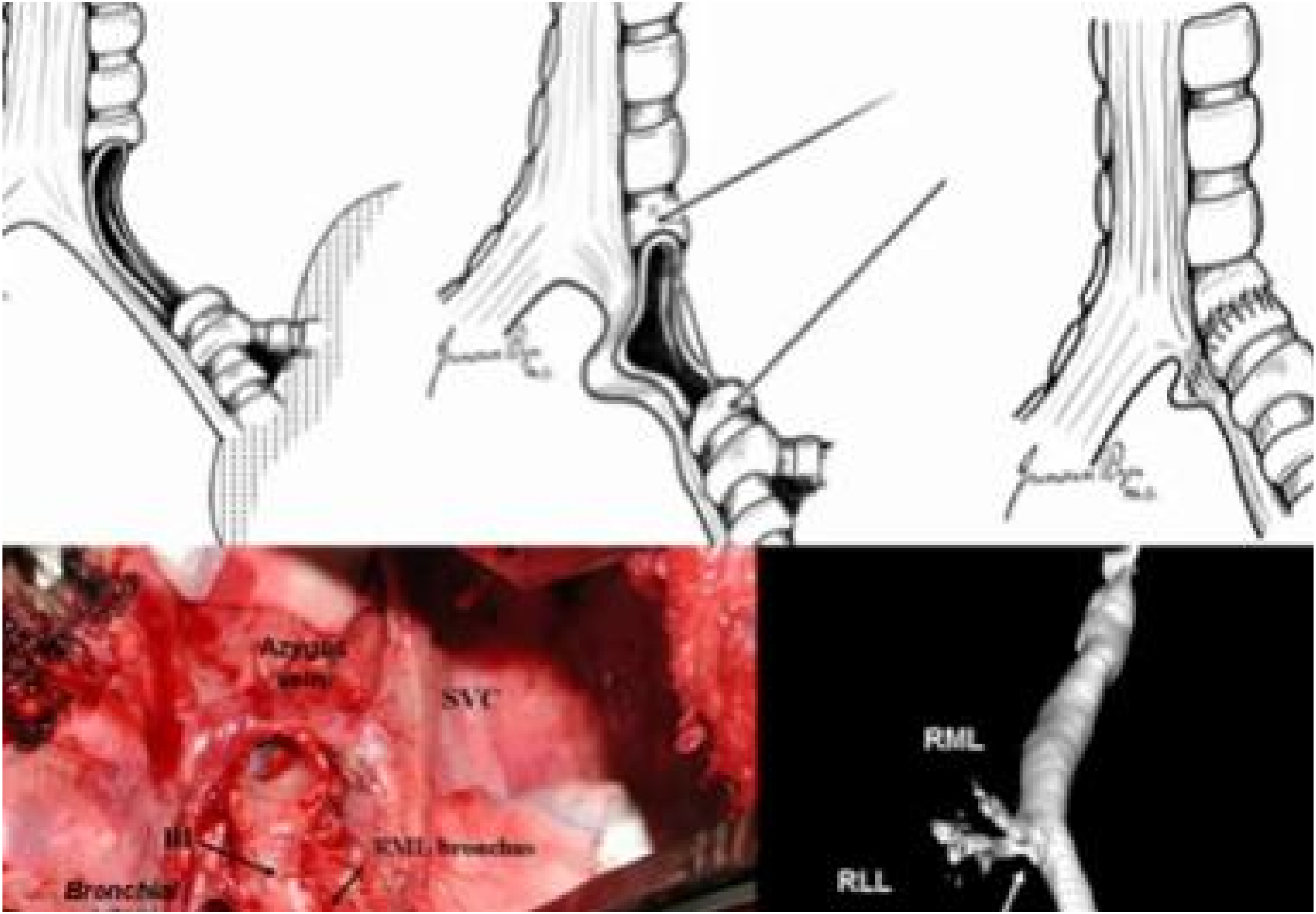
ogressive improvement in # LN sampled and in

Patients

From 2001 to 2009

≥ Lobectomy for primary NSCLC; 2006

191 wedge bronchoplastic lobectomy
43 sleeve lobectomy

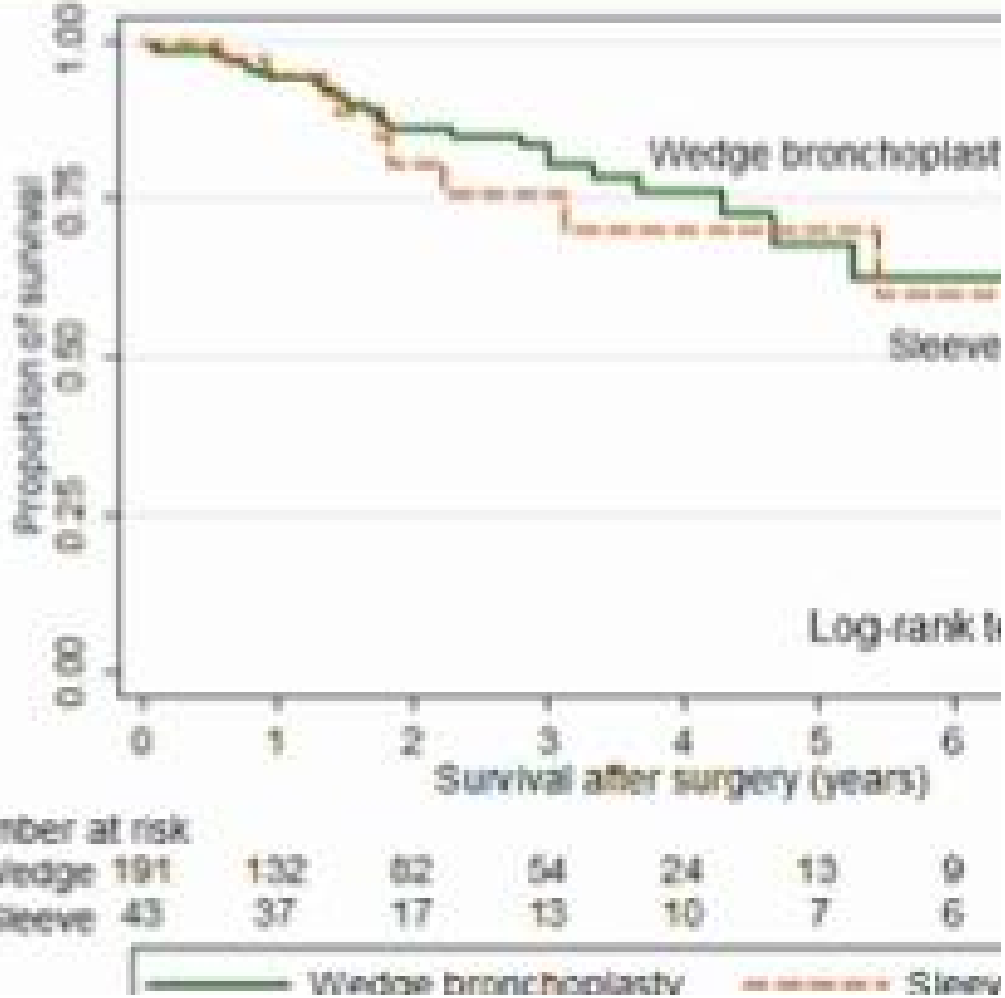

Azygos vein
SVC
RML
RLL

Variables	Sleeve lobectomy (n=43)	Wedge bronchoplastic lobectomy (n=191)
on time (min)	261.4 ± 70.9	232.9 ± 69.5
ality	2 (4.7%)	7 (3.7%)
al stenosis	7 (16.3%)	5 (2.6%)
pleural fistula	1 (2.3%)	3 (1.6%)
ry (ALI or ARDS)	5 (11.6%)	8 (4.2%)
tion (CIS or carcinoma)	5 (11.6%)	8 (4.2%)
urrence	6 (14.8%)	17 (8.9%)

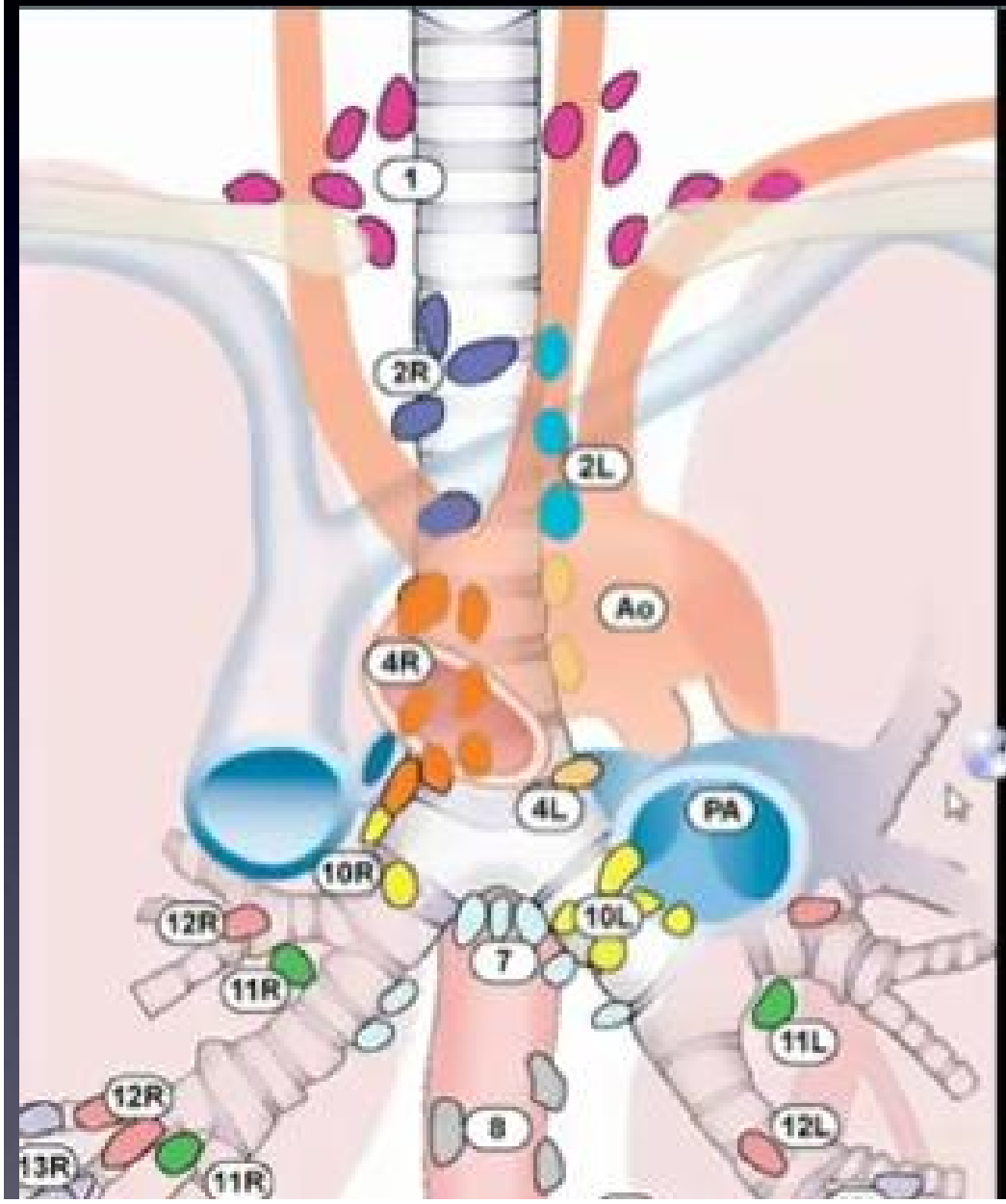
Sleeve lobectomy vs. Wedge bronchoplasty

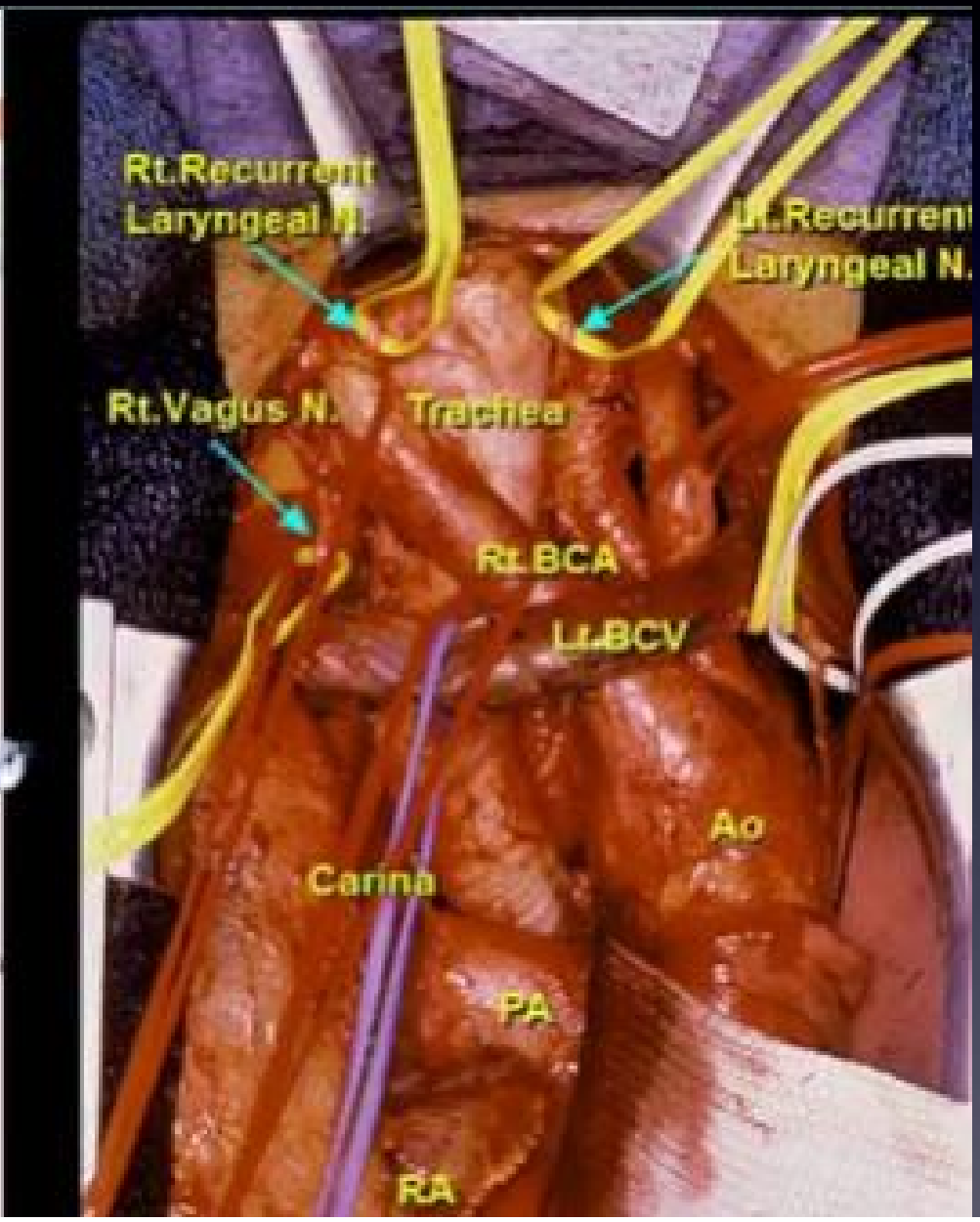
Overall survival

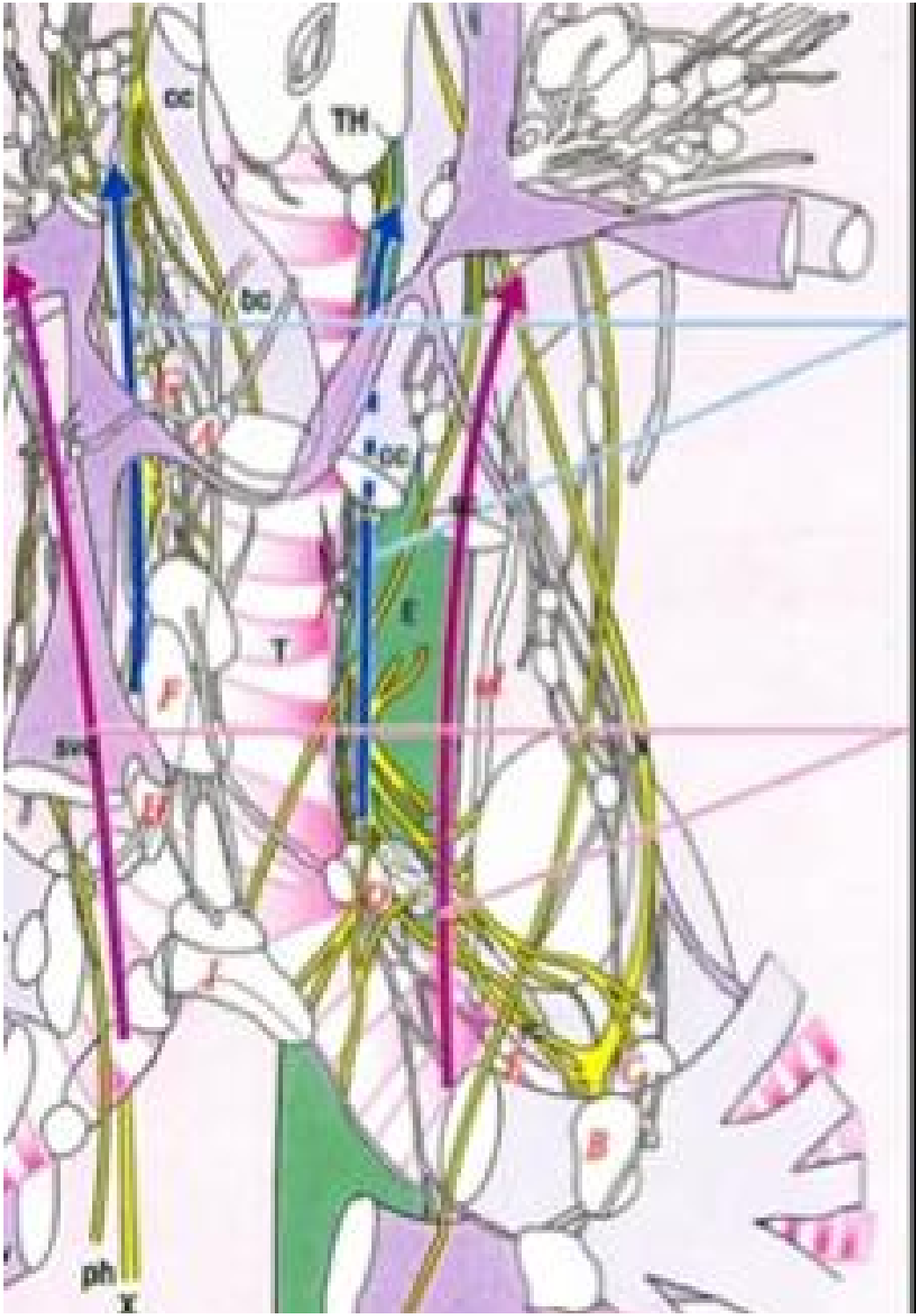
Freedom from loco-regional recu



Diseksiyonu



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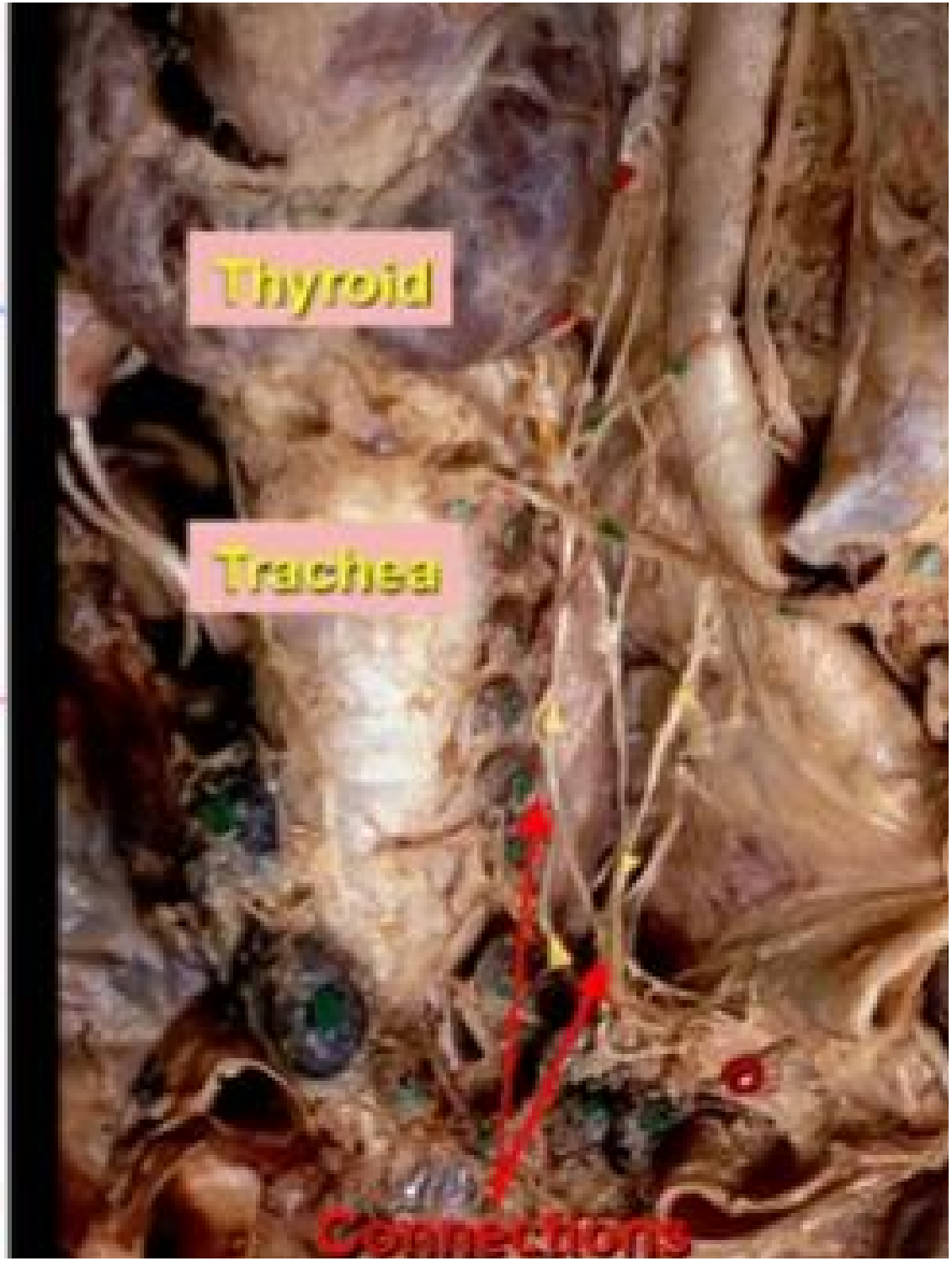

Thyroid
Trachea
Connections

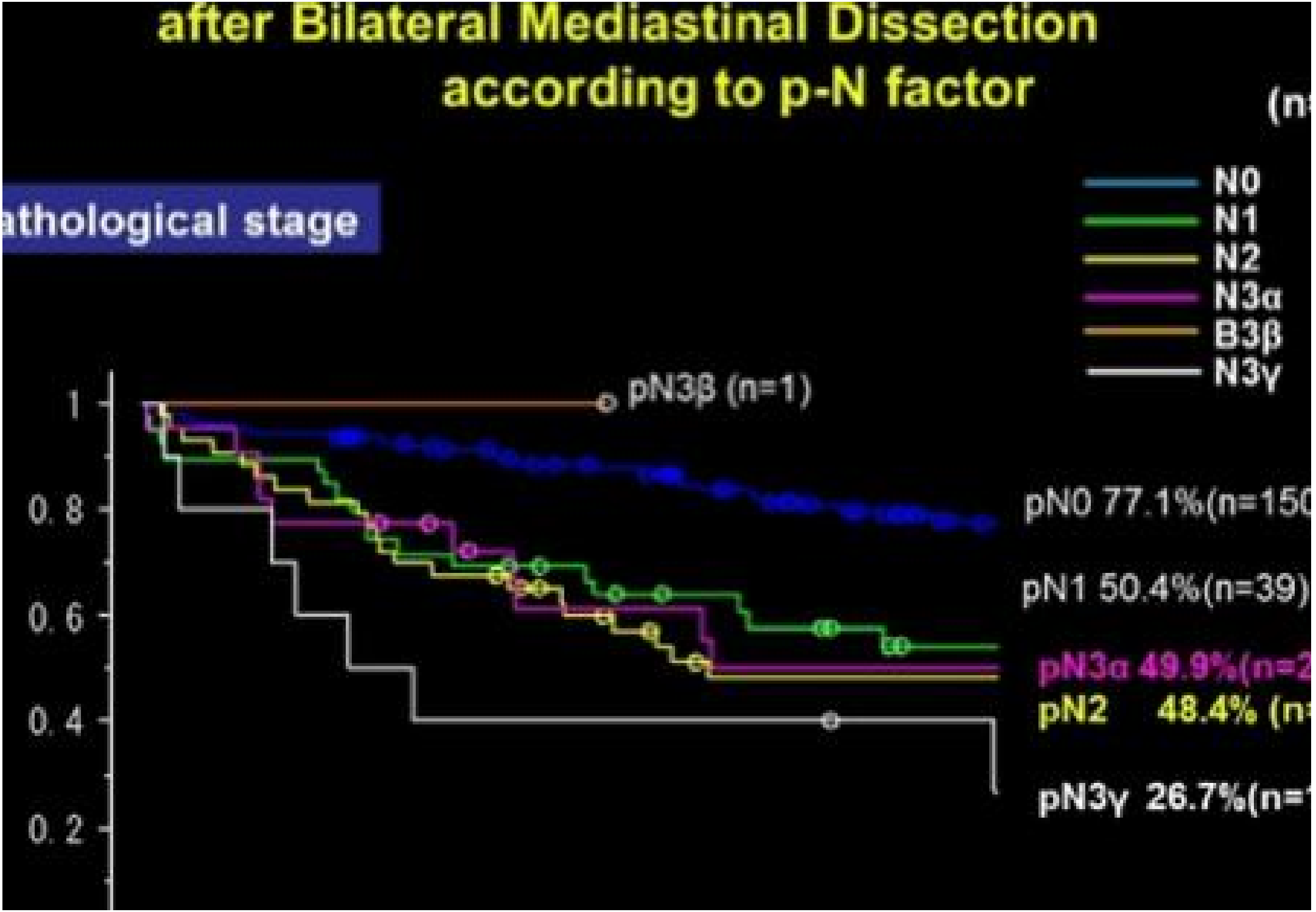
Extended bilateral mediastinal lymph node dissection through a median sternotomy

thological stage

IA : 66	24.9%	
IB: 48	18.1%	
IIA: 39	14.7%	
IIB: 21	7.9%	
IIIA: 52	19.6%	
IIIB: 39	14.7%	

n=2

	T1	T2	T3	T4	
N0	66	63	19	2	150 (56.6
N1	3	23	11	2	39 (14.7
N2	6	20	15	2	43 (16.2
N3	5	19	8	1	33 (12.4


after Bilateral Mediastinal Dissection
according to p-N factor
athological stage
N0
N1
N2
N3α
B3β
N3γ
pN3β (n=1)
1
0. 8
0. 6
0. 4
0. 2
pN0 77.1%(n=150
pN1 50.4%(n=39)
pN3α 49.9%(n=2
pN2 48.4% (n
pN3γ 26.7%(n=