Stage III NSCLC (EGFR+): A complicated case complicated by COVID

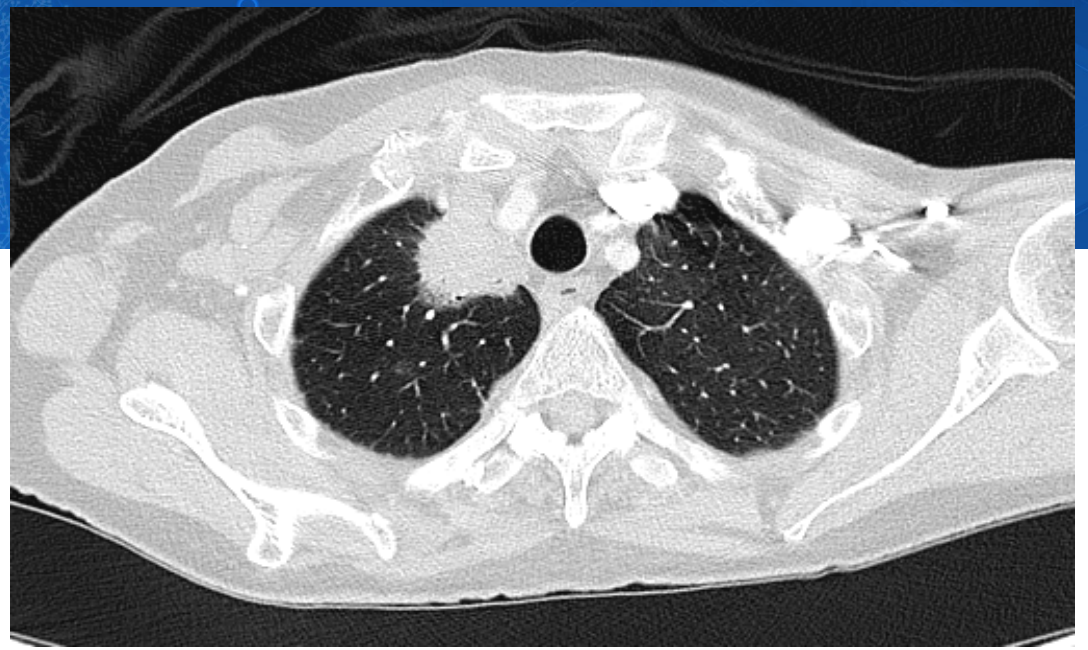
Breakout Room Moderator

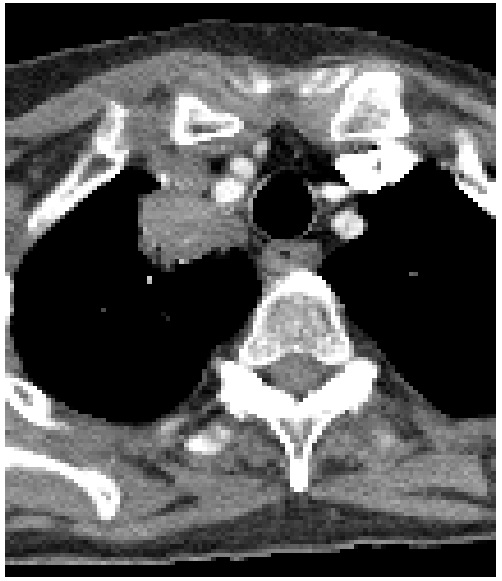
- Individual whose last name starts with the letter closest to A in the alphabet will serve as the group moderator
- **Breakout moderator role:**
    1. Make sure you have the questions
    2. Ensure conversation stays on track
    3. Encourage all members to participate
- You will be in breakout rooms for 10 mins and will automatically be pulled back into main room.
- There will be polling questions once you return to the main room. Everyone should feel fee to answer these.

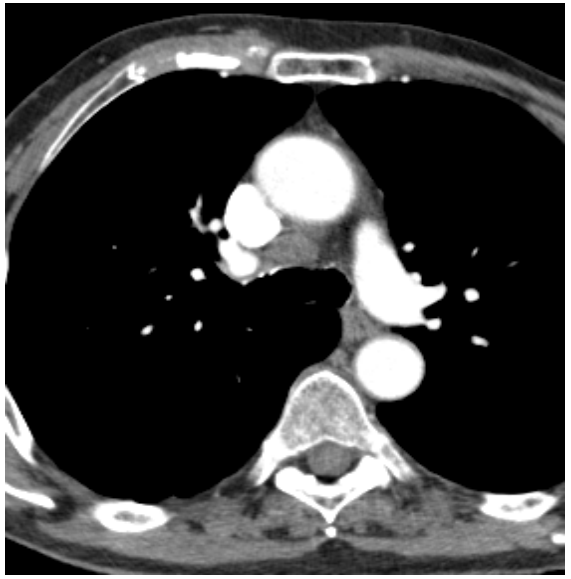
- Discussion questions
  - **What would your plan be if surgery was going to be performed in the near future (8-16 weeks)?**
  - **What would your plan be if surgery is no longer an option**
  - **Does PACIFIC apply from a perspective of a neoadjuvant case or driver mutation**

Case Information

- 76 y/o female w/ light smoking history presents for evaluation of 3 cm RULobe mass found on chest CT performed for chest wall discomfort.
- Denies respiratory symptoms, discomfort located at lateral border of scar
- PMH: early stage Breast Ca x 2, 2008 & 2018, Radiculopathy
- PSH: Spine surgery 2014, L mastectomy 2008, R mastectomy 2018, tonsillectomy as child
- Social Hx: 10 pack year history, quit 1970, no ETOH use, married, retired teacher
- Family Hx: daughter diagnosed w/ stage IV NSCLC at age 33



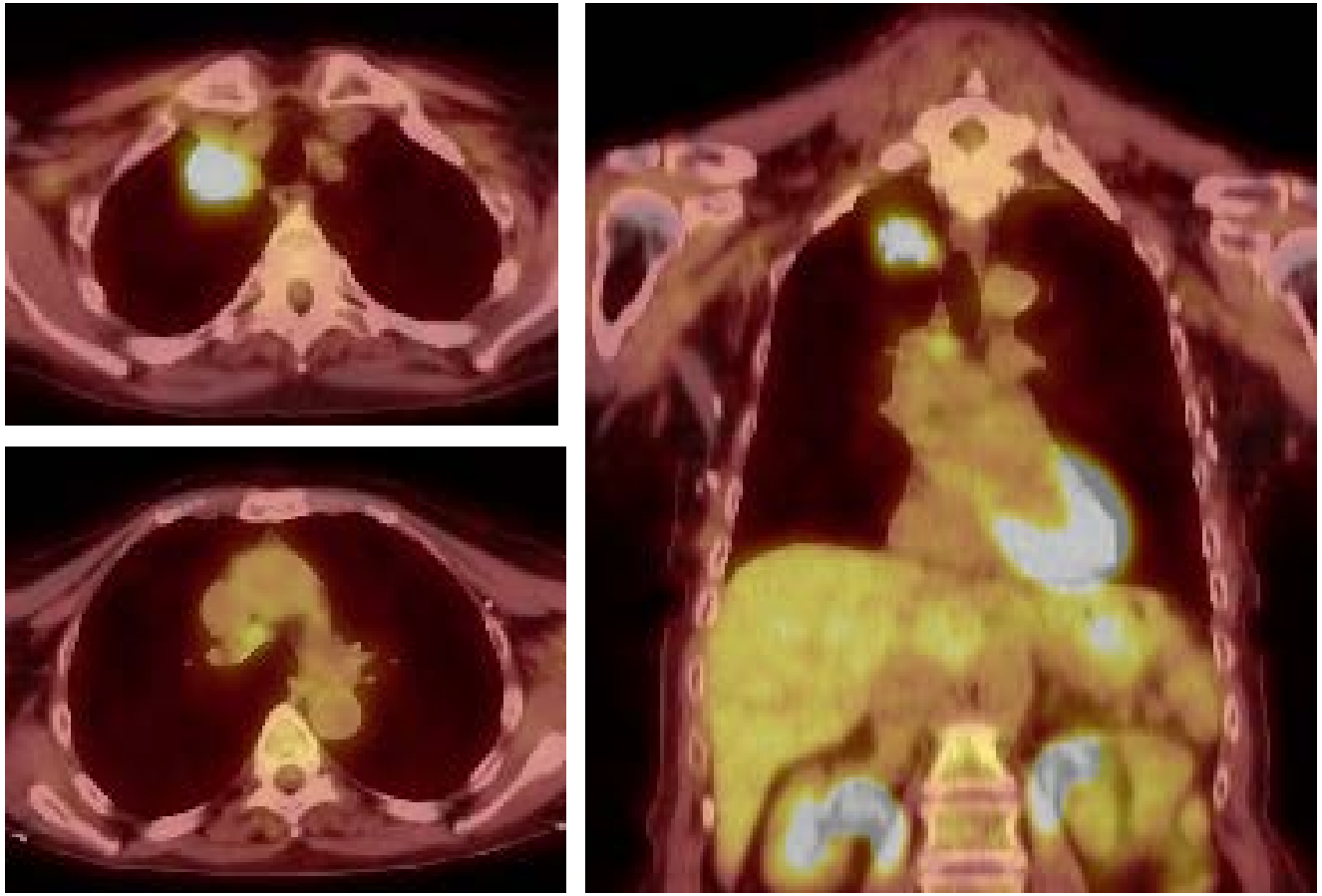


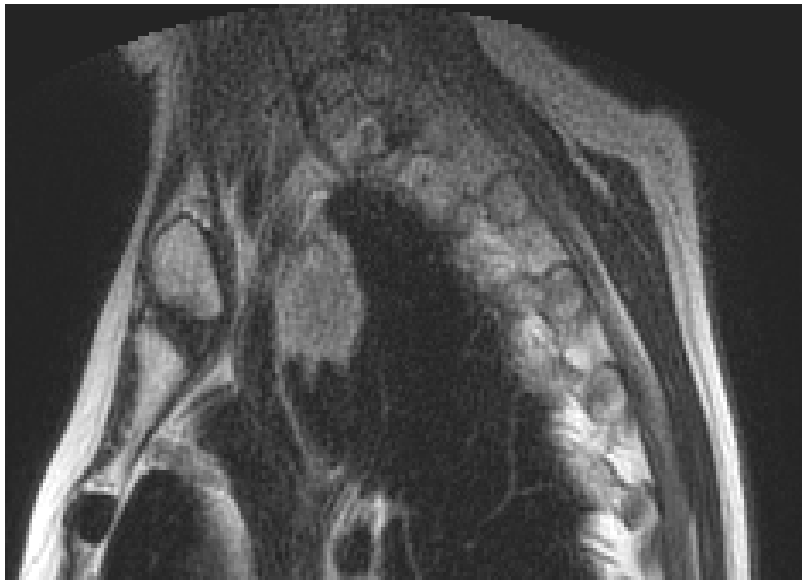


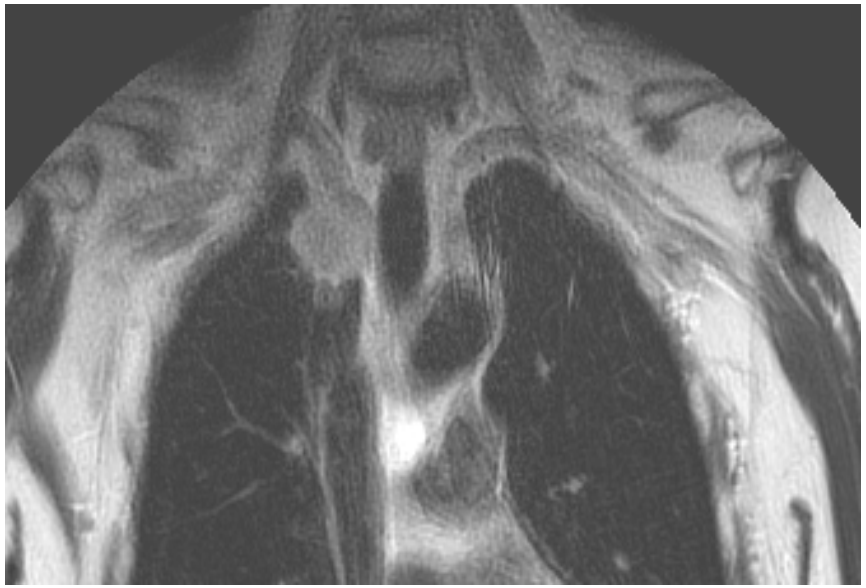
Physical Exam:

- unremarkable
- PS 0
- Bilateral mastectomies
- R chest wall pain reproducible w/ palpation at lateral mastectomy wound
- No palpable lymphadenopathy
- No tenderness in shoulder, normal strength in upper extremity B
- Lungs clear Bilateral

PET/CT: intense uptake in the apical mass and moderate uptake in R hilar and paratracheal lymph nodes, no other sites of uptake

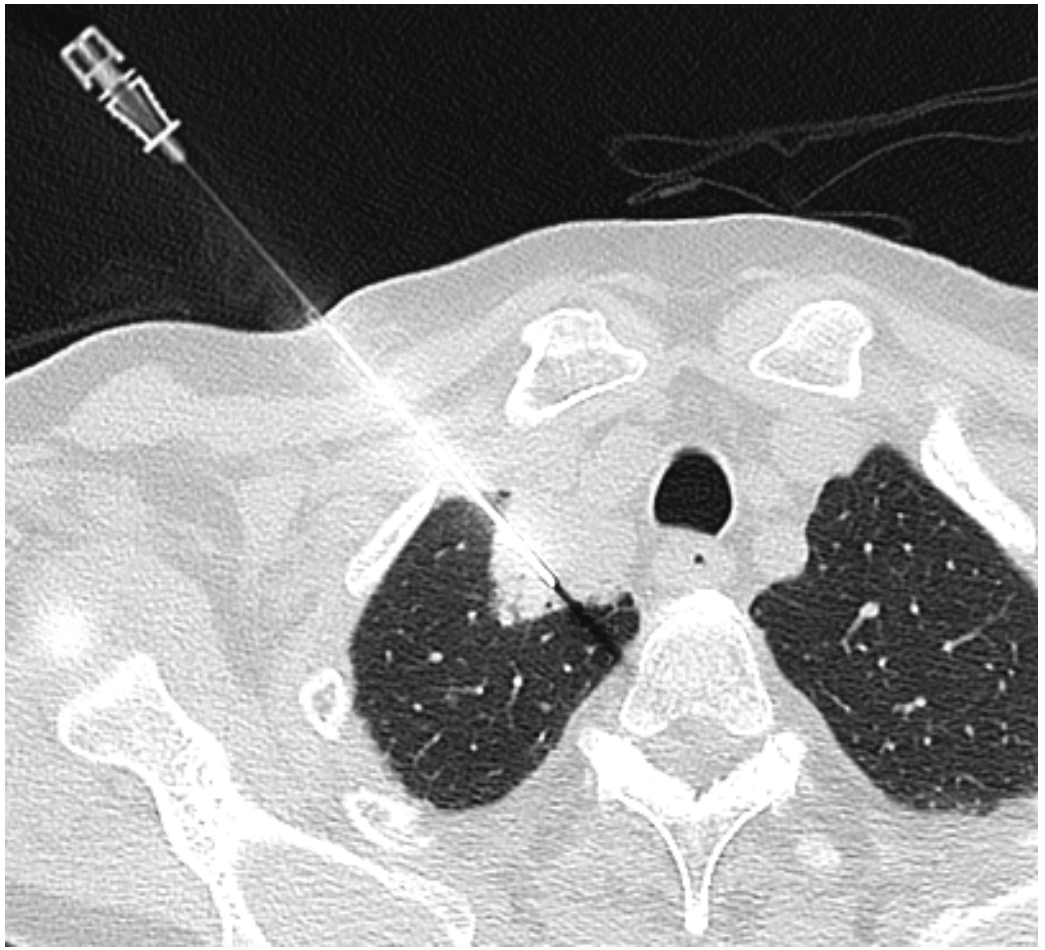






MRI: showed mass abutting subclavian artery and vein, but without evidence for invasion.

CT guided needle biopsy:
RULobe mass consistent with adenocarcinoma, TTF-1(+), PD-L1(-), EGFR “L858R”(+)



Bronchoscopy, EBUS and biopsy:

- Airway exam normal
- 4R: 15mm node (+) adenocarcinoma
- 4L and 7: no nodes visualized or sampled

PFTs:

- FVC: 2.69 L (92% pred)
- FEV1: 2.05 L (101% pred)
- DLCO: 19.50 (111% pred)

Diagnosis: cT1cN2M0 adenocarcinoma

- Stage IIIA
- Fit patient
- EGFR mutation
- Single station N2 involvement
- Tumor abuts apical pleura

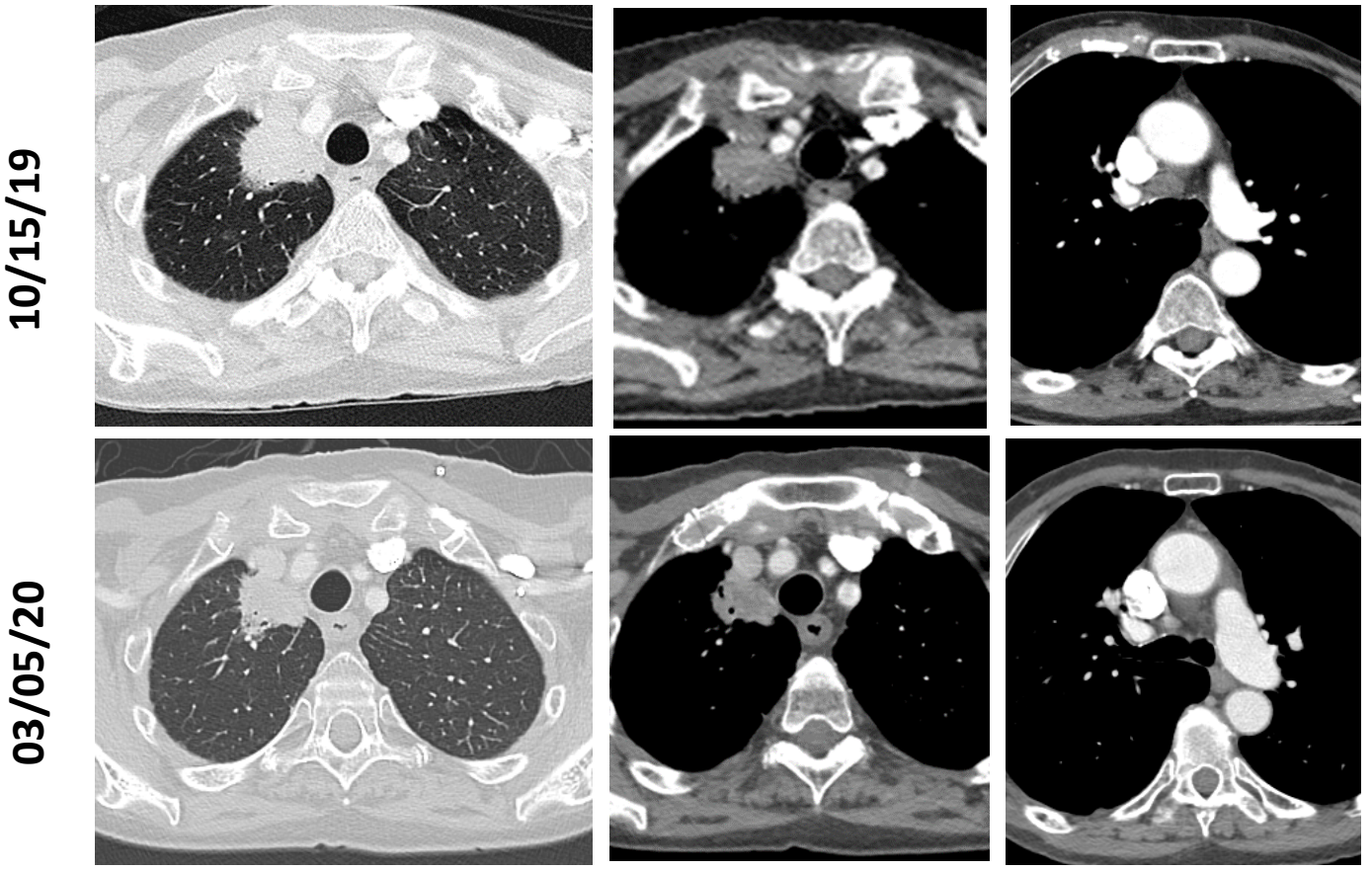
Treatment History

- Induction therapy followed by resection
- 5 cycles of cisplatin + etoposide w/ concurrent thoracic XRT to 60 Gy
- Tolerated induction well, lost 12#s, but maintain 5000 steps/day

PFTs			
	FCV	FEV1	DLCO
10/21/19	2.7 L (92%)	2.1 L (101%)	19.5 (111%)
02/20/20	2.6 L (90%)	2.1 L (91%)	15.3 (53%)
03/12/20	2.7 L (90%)	2.1 L (91%)	16.2 (57%)

PFTs with significant decrease in diffusion capacity

Post-induction CT with stable disease



- **02/27/20:** Induction therapy completed

- **03/17/20:** IL Department of Public Health recommend cancelling **ALL elective surgeries and procedures** to immediately decompress the healthcare system during the COVID-19 response

- **03/20/20:** Governor issued a “shelter in place” order for state residents, directed non-essential businesses to cease operations and prohibited public gatherings.

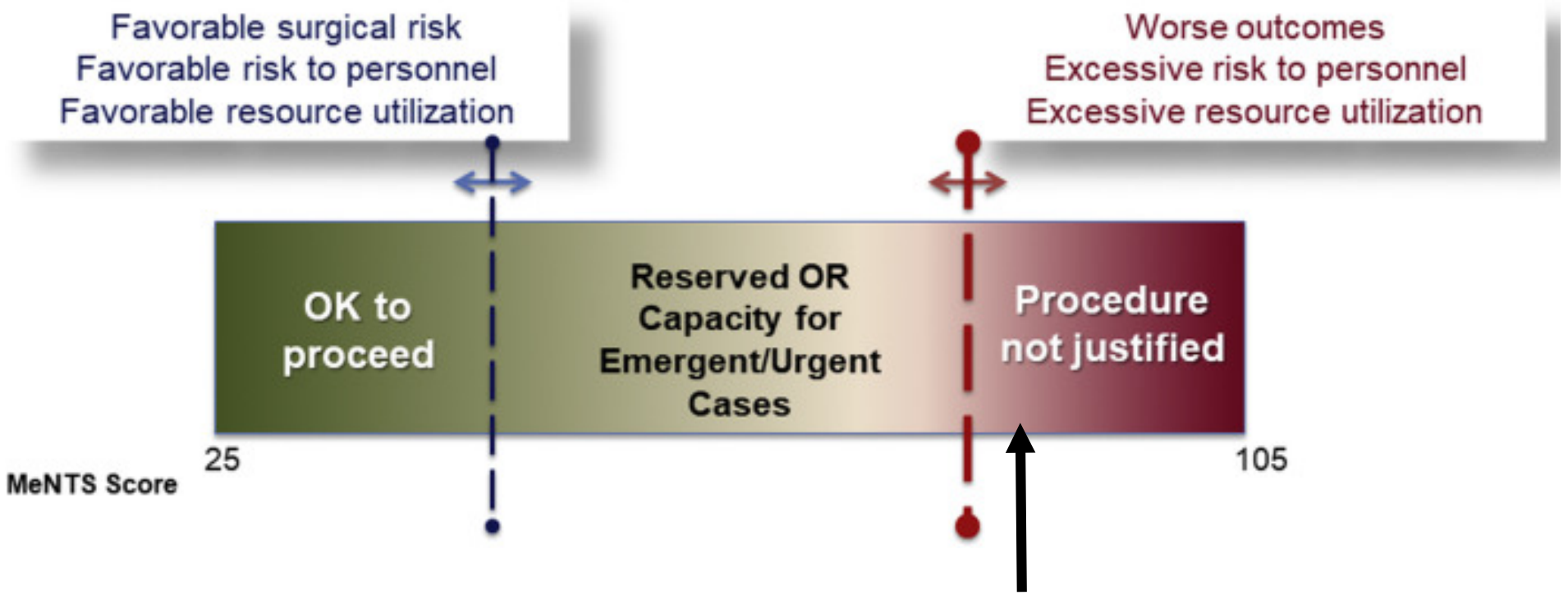
SPECIAL ARTICLE

Medically Necessary, Time-Sensitive Procedures: Scoring System to Ethically and Efficiently Manage Resource Scarcity and Provider Risk During the COVID-19 Pandemic

Vivek N Prachand, MD, FACS, Ross Milner, MD, FACS, Peter Angelos, MD, FACS, Mitchell C Posner, MD, FACS, John J Fung, MD, FACS, Nishant Agrawal, MD, FACS, Valluvan Jeevanandam, MD, FACS, Jeffrey B Matthews, MD, FACS

Patient	Procedure	Disease
Age	Resource utilization	Severity
Co-morbidity	OR time	Impact of 2-6 week delay
Risk for COVID infection	LOS and ICU beds	Potential alternative tx

MeNTS Procedure Prioritization



MeNTS score 72: due to age, immune suppression, complexity of procedure, and potential for other therapies