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DIAGNOSIS AND MANAGEMENT OF LUNG CANCER: ACCP GUIDELINES (2ND EDITION)

Special Treatment Issues in Lung Cancer: ACCP Evidence-Based Clinical Practice Guidelines (2nd Edition)

Shen, K. Robert MD ^a ... Jones, David R. MD, FCCP ^a  

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Background

This chapter of the guidelines addresses patients who have particular forms of non-small cell lung cancer that require special considerations. This includes patients with Pancoast tumors, T4N0,1M0 tumors, satellite nodules in the same lobe, synchronous and metachronous multiple primary lung cancers (MPLCs), solitary brain and adrenal metastases, and chest wall involvement.

Methods

The nature of these special clinical cases is such that in most cases, metaanalyses or large prospective studies of patients are not available. For ensuring that these guidelines were supported by the most current data available, publications that were appropriate to the topics covered in this chapter were obtained by performance of a literature search of the MEDLINE computerized database. When possible, we also referenced other

consensus opinion statements. Recommendations were developed by the writing committee, graded by a standardized method (see “Methodology for Lung Cancer Evidence Review and Guideline Development” chapter), and reviewed by all members of the lung cancer panel before approval by the Thoracic Oncology Network, Health and Science Policy Committee, and the Board of Regents of the American College of Chest Physicians.

Results

In patients with a Pancoast tumor, a multimodality approach seems to be optimal, involving chemoradiotherapy and surgical resection, provided appropriate staging has been conducted. Patients with central T4 tumors that do not have mediastinal node involvement are uncommon. Such patients, however, seem to benefit from resection as part of the treatment as opposed to chemoradiotherapy alone when carefully staged and selected. Patients with a satellite lesion in the same lobe as the primary tumor have a good prognosis and require no modification of the approach to evaluation and treatment than what would be dictated by the primary tumor alone. However, it is difficult to know how best to treat patients with a focus of the same type of cancer in a different lobe. Although MPLCs do occur, the survival results after resection for either a synchronous presentation or a metachronous presentation with an interval of < 4 years between tumors are variable and generally poor, suggesting that many of these patients may have had a pulmonary metastasis rather than a second primary lung cancer. A thorough and careful evaluation of these patients is warranted to try to differentiate between patients with a metastasis and a second primary lung cancer, although criteria to distinguish them have not been defined. Selected patients with a solitary focus of metastatic disease in the brain or adrenal gland seem to benefit substantially from resection. This is particularly true in patients with a long disease-free interval. Finally, in patients with chest wall involvement, as long as tumors can be completely resected and there is absence of N2 nodal involvement, primary surgical treatment should be considered.

Conclusions

Carefully selected patients may benefit from an aggressive surgical approach.



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Keywords

adrenal metastasis; brain metastasis; carina; metachronous primary lung cancers; multiple primary lung cancer; Pancoast tumor; satellite nodules; superior sulcus tumor; superior vena cava; synchronous primary lung cancers; T4N0,1M0 tumor

Abbreviations

ACCP, American College of Chest Physicians; MPLC, multiple primary lung cancer; NSCLC, non-small cell lung cancer; PET, positron emission tomography; WBRT, whole-brain radiotherapy

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