Pursuit of tissue: are we doing patients a disservice?

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Background: Whilst pursuit of a histological diagnosis in patients with suspected lung cancer (LC) and good performance status (PS) is indisputable, the advent of novel anti-cancer agents is making us re-examine our approach in patients with poor performance status. NICE guidelines advocate use of anti-cancer therapies in patients with PS 0–1 (37.1% of LC patients locally); (NICE 2011); this contrasts with National Lung Cancer Audit recommendations concerning optimal pathological diagnosis rates (≥80%) (NLCA 2017). Our work evaluates local pathological confirmation rates in patients with poor performance status (3–4) and its impact on patient care.

Method: All new LC diagnoses over a 12 month period were identified and data collated retrospectively through the CAN-ISC database and electronic record system. Analysis of whether pathological confirmation impacted on the MDT’s treatment plan was undertaken.

Results: Overall, 277 patients were diagnosed with LC over the 12 month period. 89 patients (32%) had a PS of 3–4 at diagnosis. The MDT treatment plan for 77% of this group was specialist palliative care or active monitoring; chemotherapy was recommended for 15 patients – 1 received it. Pathological confirmation was obtained in 38% of PS 3–4 patients (43% adenocarcinoma); it influenced management in 43% of these. Histocytological diagnoses were achieved in 4 patients of PS 4 through a variety of invasive investigations; some unscheduled (pathological fracture fixation), others reflecting diagnostic uncertainty.

Discussion: Historically LC patients with a poor performance status received best supportive care and securing a tissue diagnosis was unnecessary. With the advent of personalised treatment and novel therapies, traditional views may need re-examining. Our data demonstrates that, whilst more patients with a poor PS may be considered suitable for anti-cancer therapy, very few receive it. Target driven practice with an unmitigated pursuit of a pathological diagnosis in poor PS patients may be associated with adverse clinical sequelae and waste of valuable resource. Scheduled tests in this population should be considered on an individual basis and involve early MDT discussion. This said, whilst pressure to reach recommended pathological confirmation rates goals remain variables on which hospital LC MDTs are measured; this blanket approach to gaining tissue is likely to continue.

REFERENCE

1. Kamalatharan G, Moorcroft C, Shah R, Taggart S. P76 when is it safe to discharge resected stage 1a/1b NSCLC from the clinic? Thorax 2014;69(2):A109–A.

Abstract P258 Figure 1 Graph showing rates of recurrence by stage of disease when metachronous disease was not included as an event of interest.

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Conclusions: This paper supports a move away from the traditional follow-up duration of 5 years by proposing a reduced programme of yearly scans in years 1, 2 and 4 for stage 1 disease, and years 1–3 for stage 2 and 3 disease. Patients who are free of disease at this point could be discharged from the clinic accepting a 1.6% annual rate of metachronous disease. More investigation is warranted on the optimal framework for surveillance within the first 2 years post-surgery.

REFERENCE

1. Kamalatharan G, Moorcroft C, Shah R, Taggart S. P76 when is it safe to discharge resected stage 1a/1b NSCLC from the clinic? Thorax 2014;69(2):A109–A.

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