PRELIMINARY INSIGHT FROM THE HELP MESO STUDY
EXPERIENCE OF DIET AND APPETITE: A QUALITATIVE PRELIMINARY INSIGHT FROM THE HELP MESO STUDY

**Abstract P13**

**Discussion** The LENT and clinical PROMISE score predicted a mortality trend in our MPE cohort however, patient survival was better than predicted. This may be due to better diagnostic pathways, improvement in cancer services over time, availability of newer treatment options or other factors. Our findings are limited by a small study population therefore a larger study can explore how primary malignancy and treatment options impact survival.

**REFERENCES**

**Figure 1a: LENT score categories**

**Figure 1b: Clinical PROMISE score categories**

**Abstract P14**

**Patients with mesothelioma and their carers experience of diet and appetite: a qualitative preliminary insight from the Help Meso study**

**Background** Evidence around diet and appetite for patients with mesothelioma is lacking, despite known links between malnutrition and adverse health outcomes in cancer patients. In patients with mesothelioma the lived experience of diet and appetite are not researched, and a better understanding could inform the design of treatment strategies. The aim of the Help-Meso study is to develop an understanding of experiences of diet and appetite in patients with mesothelioma and their informal carers and to consider the opportunities for dietary interventions to prevent and treat poor appetite or malnutrition.

**Method** Nine patients and nine informal carers have been interviewed to date and interviews are ongoing. Open ended questions focussed on experiences of diet and appetite. The Help-Meso study was granted ethical approval from Wales Health Service Research and Development approvals. The study was funded by Mesothelioma UK.

**Findings** Patients with mesothelioma experience weight loss and appetite problems during the diagnostic pathway, whilst undergoing medical intervention and because of mesothelioma related symptoms (breathlessness, fatigue, pain and feeling bloated). Strategies to managing diet and appetite included taking a daily approach, with individuals eating in accordance with taste preferences and because of physical symptoms. Family played a key role in managing their relative’s diet through various ways of coping, this included implementing their own nutritional interventions (use of high calorie food intake and using supplements).

**Conclusion** Preliminary findings suggest that there are significant appetite symptoms that are often overlooked and that the caregiver take on responsibility of managing dietary behaviour. Completion of the study will give further insight to plan further interventional work.

**Abstract P15**

**Surgical resection results in prolonged survival in patients with stage III NSCLC**

**Introduction** Treatment of patients with non-small cell lung cancer (NSCLC) in UICC stage III requires a combined multimodal approach including surgical resection, chemotherap–y and immunotherapy. Yet the role of surgical resection is discussed controversially. Therefore, we sought to study the effect of surgical resection being part of the treatment concept on survival in those patients.

**Methods** Retrospective investigation of reported data of the regional cancer registry (Baden-Württemberg, Germany) including all patients with NSCLC staged UICC III between 2015 and 2021 and at least 12 months follow up. Analysis of demographic data, treatment regimen and overall survival was performed. In addition to descriptive statistics, Kaplan-Meier curves were calculated to compare overall survival of patients with surgical resection being part of the therapy vs. those without surgical resection.

**Results** A total of 6784 patients staged UICC III were included, 66.4% female, 33.6% male with a median age of 67 and 69 years. Adenocarcinomas counted for 45%, squamous cell carcinomas for 46%. As for UICC stages percentages for IIIA, IIIB and IIIC were 47.7%, 37.3% and 15% respectively. Median overall survival according for stages IIIA, IIIB and IIIC was 26.2, 17.5. and 10.5. months correspondingly. A
multimodal therapeutic approach was completed in 56% of patients. In patients in whom surgical resection was part of the therapy, median overall survival was 45.9 months as compared to patients without resection: 16.0 months (p<0.0001). This benefit was independent of primary histology and subgroup.

Conclusion Treatment of patients with stage III NSCLC is multimodal. If surgical resection is part of the multimodal approach, survival can significantly be improved as compared to patients in whom resection is not performed. Therefore, patients with stage III NSCLC should be resected whenever possible. If primary resection cannot be achieved, concepts should aim at reduction of the tumor burden, e.g. by neoadjuvant concepts, in order to realize secondary tumor resection and prolong survival.

**CLINICAL MANAGEMENT AND OUTCOMES OF GRANULOMATOUS INFLAMMATION FOLLOWING LUNG RESECTION: A RETROSPECTIVE CASE SERIES STUDY**

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Granulomatous inflammation (GI) is a common non-cancerous finding following resection for suspected lung cancer. With the implementation of lung cancer screening, it has the potential to become a significant disease burden. Yet, there is limited evidence regarding management and outcomes.

Methods A retrospective case series of patients with GI confirmed at lung resection for suspected lung cancer across three East Midlands NHS Trusts between January 2019 and December 2021. Patient demographics, imaging characteristics, operative procedure, histology, clinical management and 12-month post-operative outcomes were recorded from hospital databases and electronic health records.

**Results** The study cohort comprised 37 patients, with 45 excised lesions. The mean age was 63 ±11.8 years with 73% (27/37) being smokers. 86% (32/37) were White-British, 11% (4/37) were Asian-Indian, and 3% (1/37) Black.

Lesions were predominantly nodules with mean size of 2.00 ±1.5 cm, and located in the right lung (69%, 31/45) and in an upper lobe (62%, 28/45). Mean Herder score was 66.5% ±26. 81% (30/37) of patients had video-assisted thoracoscopy and 81% (30/37) had a wedge resection. 82% (37/45) of nodules showed necrosis on histology of which 22% (8/37) identified acid fast bacilli. Twenty-four patients (65%) had contemporaneous samples sent for microbiology of which five (21%) were positive: 3 grew NTMD, 1 fungi and 1 other bacteria (not specified). Nine patients (24%) were subsequently tested with QuantiFERON and only one was positive. Seven patients (19%) received empirical anti-tuberculous treatment (ATT) of which only four (57%) tolerated and completed the full course. There were no significant factors associated with patients having microbiological sampling, testing positive or receiving ATT.

All patients remained well at 12-month follow-up. Nine patients had follow-up imaging with no radiological recurrence.

**Conclusion** GI should be suspected in the pathology of upper lobe nodules. Our study highlights variability in the investigation and management of this heterogeneous condition. Further research in larger cohorts is needed to improve characterisation, inform outcomes and recommend appropriate management strategies for this patient cohort. Surgical specimens should routinely be sent for microbiological testing. While tuberculosis should be considered in the differential diagnosis, our data suggests this is uncommon.

**Abstract P16 Table 1 Demographics, management and outcomes of patients who received anti-tuberculous treatment**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Age</th>
<th>Sex</th>
<th>Smoker</th>
<th>PET</th>
<th>Thoracotomy/ VATS</th>
<th>Wedge/ Lobectomy</th>
<th>Histology</th>
<th>Surgical sample for Microbiology</th>
<th>QFT</th>
<th>Course</th>
<th>Imaging</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 White - British</td>
<td>71</td>
<td>F</td>
<td>No</td>
<td>Intense</td>
<td>VATS</td>
<td>Wedge</td>
<td>NGI with AFB seen on staining</td>
<td>Yes – Negative</td>
<td>Positive</td>
<td>Completed ATT</td>
<td>6 months post-operative CT scan – No changes</td>
</tr>
<tr>
<td>2 Asian - Indian</td>
<td>41</td>
<td>M</td>
<td>Yes</td>
<td>Intense</td>
<td>VATS</td>
<td>Biopsy</td>
<td>NGI</td>
<td>Not sent</td>
<td>Not done</td>
<td>Completed ATT</td>
<td>No follow up imaging</td>
</tr>
<tr>
<td>3 Asian - Indian</td>
<td>63</td>
<td>F</td>
<td>Yes</td>
<td>Moderate</td>
<td>VATS</td>
<td>Wedge</td>
<td>NGI</td>
<td>Yes – Negative</td>
<td>Not done</td>
<td>Completed ATT</td>
<td>No follow up imaging</td>
</tr>
<tr>
<td>4 White - British</td>
<td>81</td>
<td>F</td>
<td>Yes</td>
<td>Moderate</td>
<td>VATS</td>
<td>Wedge</td>
<td>NGI</td>
<td>Yes – M Kansasii</td>
<td>Not done</td>
<td>ATT discontinued following drug induced hepatitis</td>
<td>6 months post-operative CT scan – No changes</td>
</tr>
<tr>
<td>5 White - British</td>
<td>63</td>
<td>M</td>
<td>Yes</td>
<td>No uptake</td>
<td>VATS</td>
<td>Wedge</td>
<td>NGI with AFB seen on staining</td>
<td>Yes – M Xenopi</td>
<td>Not done</td>
<td>Intolerant of ATT. Discontinued</td>
<td>No follow up imaging</td>
</tr>
<tr>
<td>6 White - British</td>
<td>66</td>
<td>F</td>
<td>No</td>
<td>Moderate</td>
<td>VATS</td>
<td>Wedge</td>
<td>NGI with AFB seen on staining</td>
<td>Yes – Negative</td>
<td>Not done</td>
<td>Completed ATT</td>
<td>No follow up imaging</td>
</tr>
<tr>
<td>7 White - British</td>
<td>47</td>
<td>M</td>
<td>Yes</td>
<td>Moderate</td>
<td>VATS</td>
<td>Wedge</td>
<td>Non Necrotising GI</td>
<td>Yes – Negative</td>
<td>Negative</td>
<td>ATT discontinued following drug induced hepatitis</td>
<td>No follow up imaging</td>
</tr>
</tbody>
</table>

VATS – Video assisted thoracoscopic surgery, NGI – Necrotising Granulomatous inflammation, ATT – Anti-tuberculous treatment, CT scan – Computerised tomography scan