PATIENTS WITH MESOTHELIOMA AND THEIR CARERS
SURGICAL RESECTION RESULTS IN PROLONGED
Thorax A114

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.

REFERENCES
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.

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>
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</thead>
<tbody>
<tr>
<td>1 White – British</td>
<td>71</td>
<td>F</td>
<td>No</td>
<td>Intense VATS</td>
<td>Wedge</td>
<td>Yes – Negative</td>
<td>Positive</td>
<td>Completed ATT</td>
<td>6 months post-treatment CT scan – No changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Asian – Indian</td>
<td>41</td>
<td>M</td>
<td>Yes</td>
<td>Intense 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>
<td></td>
</tr>
<tr>
<td>3 Asian – Indian</td>
<td>63</td>
<td>F</td>
<td>Yes</td>
<td>Moderate VATS</td>
<td>Wedge</td>
<td>NGI</td>
<td>Not done</td>
<td>Completed ATT</td>
<td>No follow up imaging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 White – British</td>
<td>81</td>
<td>F</td>
<td>Yes</td>
<td>Moderate VATS</td>
<td>Wedge</td>
<td>Yes – M Kansasi</td>
<td>Not done</td>
<td>ATT discontinued following drug induced hepatitis</td>
<td>6 months post-operative CT scan – No changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 White – British</td>
<td>63</td>
<td>M</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>
<td></td>
</tr>
<tr>
<td>6 White – British</td>
<td>66</td>
<td>F</td>
<td>No</td>
<td>Moderate 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>
<td></td>
</tr>
<tr>
<td>7 White – British</td>
<td>47</td>
<td>M</td>
<td>Yes</td>
<td>Moderate 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>
<td></td>
</tr>
</tbody>
</table>

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