

The background is a dark blue gradient with a subtle pattern of small white dots. On the left side, there are several overlapping circular elements. A prominent one is a large circle with a scale around its perimeter, ranging from 140 to 260 in increments of 10. Other circles are smaller and some have dashed outlines or arrows pointing in various directions, creating a sense of motion or a technical diagram.

FOLLOW UP IN LUNG CANCER

CAGPO 2016

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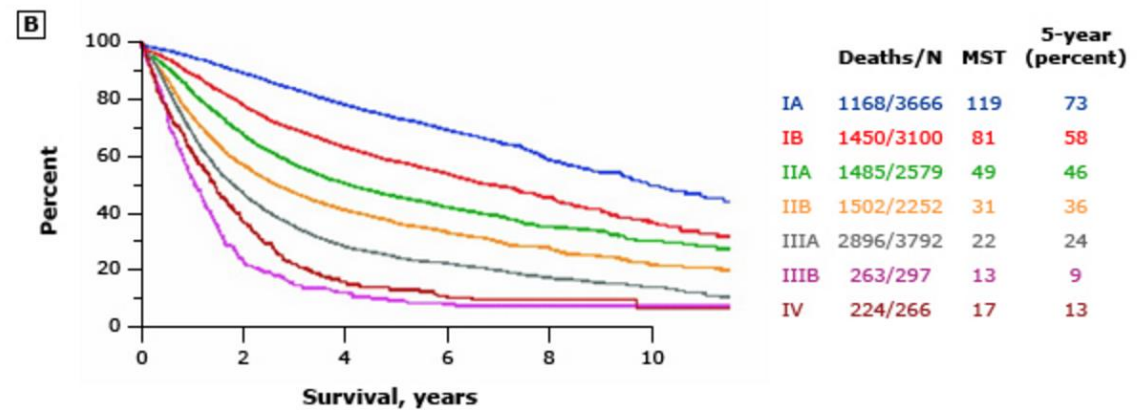
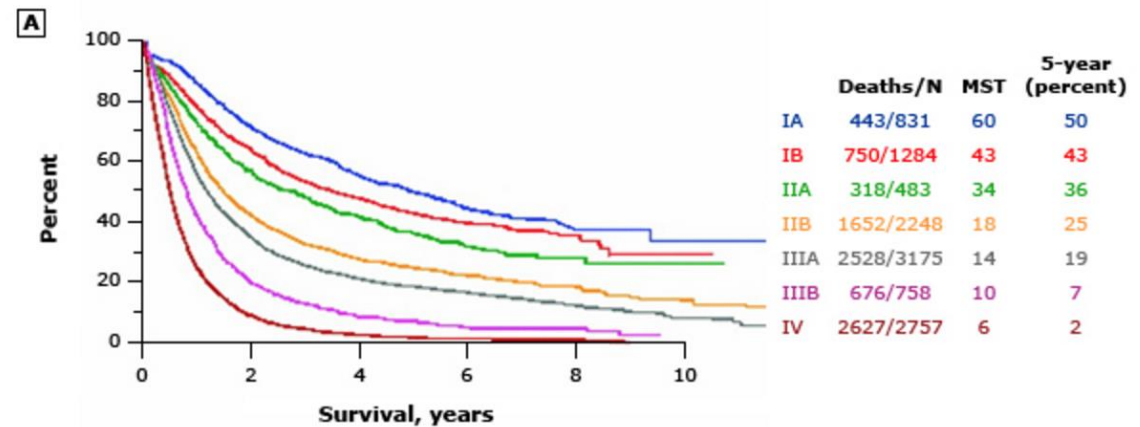
BC CANCER AGENCY – VANCOUVER CENTER

DISCLOSURES / CONFLICTS OF INTEREST

Not important enough to receive compensation for my opinion 😊

FOLLOW UP:
WHY DO WE DO IT?

Overall survival by TNM grouping, non-small cell lung cancer



Overall survival, expressed as median survival time (MST) and five-year survival, using the seventh edition of TNM staging system by (A) clinical stage and (B) pathologic stage.

Reproduced with permission from: Goldstraw P, Crowley J, Chansky K, et al. The IASLC Lung Cancer Staging Project: proposals for the revision of the TNM stage groupings in the forthcoming (seventh) edition of the TNM Classification of malignant tumours. *J Thorac Oncol* 2007; 2:706. Copyright © 2007 Lippincott Williams & Wilkins.

FOLLOW UP: WHY DO IT?

- Detect a recurrence
- Detect a new primary lung cancer
- Most often detect metastatic disease – Benefit to earlier detection?
 - Assessment for targeted therapies
 - Better performance status for systemic therapy
 - ? Impact on OS

WHAT ARE THE GUIDELINES?



NON-SMALL CELL LUNG CANCER (NON-METASTATIC)

Organization	Follow up visits	CT imaging
American College of Chest Physicians	Every 6 months for 2 years then annually	Every 6 months for 2 years then annually
Cancer Care Ontario	Every 3 months for 2 years, every 6 months for year 3 then annually	Year 1: 3, 6, 12 months Year 2: every 6 months Year 3: Annually
European Society of Medical Oncology	Every 6 months for 2-3 years then annually	Early Stage: Annually Advanced: every 6 months for 2 years then annually
National Comprehensive Cancer Network	Every 6-12 months for 2 years then annually	Every 6-12 months for 2 years then annually

NON-SMALL CELL LUNG CANCER (NON-METASTATIC)

- Quality of data is poor– No evidence from large randomized trials is available to define optimal follow-up
- Systematic review of observational studies: trend towards intensive follow-up for OS, asymptomatic recurrence significant for increased survival – incl both NSCLC and SCLC (*J Thorac Oncol. 2011 Dec;6(12):1993-2004.*)
- Also, no good evidence for surveillance biomarkers, PET Scan, etc; some data suggests PET may be more sensitive, but more radiation, small studies, ?OS benefit
- CXR? Some evidence CT may be better at picking up recurrences (*NLST – early detection, J Thorac Cardiovasc Surg. 2014 Jan;147(1):30-3*) but no OS data
- Personalized follow up important – higher vs. lower risk of recurrence, staging, co-morbidities, patient preference, radiation risk
- More intensive early on? More recur in the first few years

SMALL CELL LUNG CANCER (LIMITED STAGE)

Organization	Follow up visits	CT imaging
Cancer Care Ontario	Every 3 months for 2 years, every 6 months for year 3 then annually	Year 1: 3, 6, 12 months Year 2: every 6 months Year 3: Annually
European Society of Medical Oncology	Every 3-6 months for 2 years then "lengthening intervals"	Every 3-6 months for 2 years then annually
National Comprehensive Cancer Network	Every 3-4 months for 2 years then q. 6 months until 5 years, then annually	Every 3-4 months for 2 years then q. 6 months until 5 years, then annually

LUNG CANCER FOLLOW-UP

- No great data regarding timing, intensity, modality, or impact on OS – may vary by institution or the guidelines followed
- Personalized follow up important – higher vs. lower risk of recurrence, pathology/staging, comorbidities, patient preference, radiation risk

HOPE FOR THE FUTURE?

[IFCT-0302 trial: randomised study comparing two follow-up schedules in completely resected non-small cell lung cancer].

(PMID:17519819)

Abstract

Citations 

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[Revue des Maladies Respiratoires](#) [2007, 24(5):645-652]

Type: Journal Article, Randomized Controlled Trial, Comparative Study, English Abstract (lang: fre)

DOI: 10.1016/S0761-8425(07)91135-3 

Abstract

BACKGROUND: The authorities advocate a minimalist attitude towards the follow-up of resected bronchial carcinoma (clinical examination and chest x-ray). A survey showed that 70% of French respiratory physicians have chosen to use the CT scanner and often endoscopy. The published data are equivocal and are often based on retrospective studies. Lung cancer is a good model for a study of post-operative surveillance. Recurrences often occur in easily observed areas, they may be detected while still asymptomatic and are sometimes potentially curable. Second primary tumours may develop at the same site.

METHODS: The Intergroupe Francophone de Cancerologie Thoracique (IFCT) has initiated a trial comparing simple follow-up (clinical examination, chest x-ray) with a more intensive follow-up (CT scan, fiberoptic bronchoscopy). The surveillance will take place every 6 months for 2 years and then annually until 5 years.

EXPECTED RESULTS: The main aim is to determine whether intensive follow-up improves patient survival. The opposite question is equally important. If an expensive and demanding follow-up does not affect the chances of cure these results will influence our practice.

THAT'S IT!



Table 5. Survival of patients with SCLC according to clinical and pathological staging.

Condition	5-year survival rate (%)	
	Clinical staging	Pathological staging
IA	38	56
IB	21	48
IIA	38	43
IIB	18	40
IIIA	13	8
IIIB	9	25

Image courtesy of Remedica Journals

<http://www.remedicajournals.com/CML-Lung-Cancer/BrowseIssues/Volum-4/Article-Incorporating-the-New-IASLC-Staging-System-for-Lung-Cancer>