

KEY QUALITY RECOMMENDATIONS:

Stage IB to IIIA Non-Small Cell Lung Cancer (NSCLC)

Care Coordination and Patient Education	<ul style="list-style-type: none"> • Standardization of patient participation in shared decision-making • Education of patients on all aspects of NSCLC management, including diagnosis, staging, prognosis, treatment options, and goals of treatment • Provision of access to a multidisciplinary team (MDT) care navigator and coordination of appointments for information on financial aspects of treatment • Provision of smoking cessation and tobacco treatment for patients who smoke or use other tobacco products • Acknowledgment and action on all identified barriers to care • Education of patients on organization and community resources • Education of patients on available clinical trials • Assessment of distress and referral to psychosocial support services throughout the continuum of care
Diagnosis and Biomarker Testing	<ul style="list-style-type: none"> • Multidisciplinary evaluation of suspicious findings • MDT coordination for efficient biopsy collection (e.g., core needle preferred, cytology acceptable) • Biomarker testing (e.g., EGFR) for patients with stage IB to IIIA NSCLC who may be eligible for targeted therapy; testing should be performed prior to initiating definitive therapy • PD-L1 (SP263) testing for patients with resected stage II to IIIA NSCLC • Discussion with patients on how EGFR targeted therapy might have higher magnitude of benefit for patients with stage II to IIIA NSCLC whose resected tumor has EGFR mutation and PD-L1 positivity
Staging, Treatment Planning, and Treatment Delivery	<ul style="list-style-type: none"> • Incorporation of invasive staging procedures for increased sensitivity and specificity • Staging and utilization of appropriate techniques to define treatment planning • Determination of resectability and resection performed by thoracic oncology surgeons who perform lung cancer surgery as a prominent part of their practice • MDT coordination for optimal multimodal treatment planning involving surgery, radiation oncology, and/or medical oncology (this may require asynchronous conversations or virtual meetings in some settings) • Utilization of brain MRI (contrast-enhanced MRI preferred, or CT with contrast for those who are ineligible for MRI) in patients with stage IB to IIIA NSCLC • Utilization of whole body PET scan • Administration of adjuvant chemotherapy, ideally given within 60 days after curative resection in patients with stage II or III NSCLC • Administration of adjuvant osimertinib for patients with resected stage IB to IIIA NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations • Administration of adjuvant atezolizumab following resection and platinum-based chemotherapy for patients with resected stage II to IIIA NSCLC whose tumors have PD-L1 expression \geq 1 percent of tumor cells • Invasive mediastinal evaluation for staging when considering non-operative approaches (e.g., stereotactic body radiation therapy or fractionated chemoradiation) in patients with stage IB to IIIA NSCLC • Sampling of lymph nodes from the mediastinum (at least 3 distinct stations from stations 2-9) and the hilum (at least 1 station from stations 10-14) during surgical resection for curative intent • Utilization of pathology synoptic report for documentation of lymph nodes from the names and/or numbers of stations • Utilization of care coordination strategies, including toxicity management and monitoring for adherence to targeted therapy

Post-Treatment Survivorship Care

- Incorporation of invasive staging procedures for increased sensitivity and specificity
- Staging and utilization of appropriate techniques to define treatment planning
- Determination of resectability and resection performed by thoracic oncology surgeons who perform lung cancer surgery as a prominent part of their practice
- MDT coordination for optimal multimodal treatment planning involving surgery, radiation oncology, and/or medical oncology (this may require asynchronous conversations or virtual meetings in some settings)
- Utilization of brain MRI (contrast-enhanced MRI preferred, or CT with contrast for those who are ineligible for MRI) in patients with stage IB to IIIA NSCLC
- Utilization of whole body PET scan
- Administration of adjuvant chemotherapy, ideally given within 60 days after curative resection in patients with stage II or III NSCLC
- Administration of adjuvant osimertinib for patients with resected stage IB to IIIA NSCLC whose tumors have EGFR exon 19 deletions or exon 21 L858R mutations
- Administration of adjuvant atezolizumab following resection and platinum-based chemotherapy for patients with resected stage II to IIIA NSCLC whose tumors have PD-L1 expression \geq 1 percent of tumor cells
- Invasive mediastinal evaluation for staging when considering non-operative approaches (e.g., stereotactic body radiation therapy or fractionated chemoradiation) in patients with stage IB to IIIA NSCLC
- Sampling of lymph nodes from the mediastinum (at least 3 distinct stations from stations 2-9) and the hilum (at least 1 station from stations 10-14) during surgical resection for curative intent
- Utilization of pathology synoptic report for documentation of lymph nodes from the names and/or numbers of stations
- Utilization of care coordination strategies, including toxicity management and monitoring for adherence to targeted therapy

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