ASSOCIATION OF COMMUNITY CANCER CENTERS

OVERVIEW OF EARLY STAGE NON-SMALL CELL LUNG CANCER SURVEY RESULTS

ACCC conducted a survey of multidisciplinary providers across the United States to assess current diagnostic, staging, and treatment practices for individuals with Stage IB-IIIA non-small cell lung cancer (NSCLC). The survey received 124 responses from multidisciplinary cancer care team members practicing in 33 states. Annual lung cancer case volumes per stage (IB, IIA/IIB, IIIA) ranged from less than 5 to more than 50.

RESPONDENT SPECIALTIES

- Oncology Nurse / Nurse Practitioner (33%)
- Medical Oncologist (23%)
- Radiation Oncologist (15%)
- Advanced Practice Provider (6%)
- Navigator (3%)
- Cancer Program Administrator (2%)
- Pulmonologist (2%)
- Thoracic Surgeon (2%)
- Pathologist (1%)
- Other (13%)

PRACTICE LOCATIONS

- 60% URBAN
- 23% SUBURBAN
- 17% RURAL

TUMOR BOARDS

Multidisciplinary tumor boards were a common practice at the sites surveyed. The frequency of tumor board meetings ranged from weekly (57%) or biweekly (22%) to monthly (11%).

BIOMARKER TESTING

FREQUENTLY ORDERED TESTS

- PDL1 (31%)
- Multi-plex panel with <50 genes (22%)
- Large panel with >50 genes (16%)
- Single mutation EGFR test (13%)
- Other genes as single tests (12%)

Most programs (66%) report having a standard biomarker testing protocol (21% do not and 12% were unsure).

Tissue-based biomarker testing is typically ordered by:
- Medical oncologists (46%)
- Surgeons (18%)
- Pathologists (17%)
- Pulmonologists (10%)
- Advanced Practice Providers (6%)

The most common reasons cited for not ordering biomarker testing on eligible early-stage patients with NSCLC include:
- Insurance ineligibility (25%)
- Patient refusal (13%)
- Physician believes the test is not needed (15%)
- Physician forgets to order the test (13%)
LIQUID BIOPSY
For patients with resected NSCLC, respondents report that liquid biopsy is ordered:

- When tissue tests are not performed (33%)
- For all patients with resected NSCLC (13%)
- Never (9%)
- Other (12%)
- Not sure (32%)

“Other” responses included: when tissue was insufficient, concurrent with tissue NGS, based on physician preference, with metastatic disease, etc.

ADJUVANT TREATMENT
When a driver mutation is identified, 40% of respondents report that adjuvant targeted therapy is initiated in <50% of patients at their institution. Adjuvant treatment decisions for individuals with resected NSCLC are most often made by:

- 68% Medical Oncologists
- 24% Multidisciplinary Clinic
- 8% Surgeon

Most respondents (83%) agree that their cancer practice has the staff and resources to adequately navigate patients with early-stage NSCLC on available services and treatment options. However, only 45% report that their site assigns a nurse navigator to the majority of patients with early-stage NSCLC.

BARRIERS TO OPTIMAL CARE
Overall, respondents report the biggest barriers to providing optimal care for early-stage lung cancer at their institutions were:

- Scheduling difficulties for diagnostic procedures and/or surgery (23%)
- Patient refusal of treatment (19%)
- Breakdown in communication between patients and cancer care team members (17%)
- Inadequate staffing resources (15%)
- Limited access to certain subspecialties (14%)
- Breakdown in communication within the cancer care team (8%)

A publication from the ACCC education program, Changing Care Patterns for Patients with Early-Stage Non-Small Cell Lung Cancer (NSCLC). Learn more at accc-cancer.org/early-NSCLC.

The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the cancer care community. For more information, visit accc-cancer.org.

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