

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/closing-gaps-nsclc/fulfilling-the-unmet-needs-of-nsclc-patients/11234/>

ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Fulfilling the Unmet Needs of NSCLC Patients

Announcer:

This is *Closing the Gaps in Non-Small Cell Lung Cancer* on ReachMD, sponsored by Lilly. On today's program, we'll hear from Dr. Deepa Rangachari, assistant professor of medicine at Harvard Medical School and attending oncologist at the Beth Israel Deaconess Medical Center. Dr. Rangachari shares some key strategies to help us better address the needs of patients with non-small cell lung cancer. Here's Dr. Rangachari now.

Dr. Rangachari:

We personally are very fortunate in our own clinic at the institution where I practice where we have worked hard to develop an integrated embedded palliative care model where at every visit—whether it's a new patient visit or a follow-up visit—patients have the opportunity not only to meet with myself and the medical oncology side of the team but also with the palliative care team, which is an interdisciplinary team and includes palliative care providers, MD or nurse practitioner, as well as social work, chaplain, etc. I think this is one important area.

Another important area is how to communicate with patients about the process of obtaining tumor-genetic testing and realistic expectations as they relate to immune checkpoint inhibitors and targeted therapies. We know now that tumor-genetic profiling at initial diagnosis is really a mandatory and evidence-based step in the care of all patients presenting with advanced-stage non-small cell lung cancer. It's important as providers that we recognize the need for this testing and that we actually get it done. There are a lot of studies from around the world showing low uptake of evidence-based and expert-advocated tumor-genetic profiling algorithms. If we don't look for the genetic alterations, we're not going to find them, and if we don't find them, we're not going to be able to offer our patients the optimal therapy.

In addition to actually recognizing the need for ordering and accurately interpreting and applying the test, we also need to talk with patients about the process for testing. Testing takes time, even with all of the technologies that we have. In many practices around the world, we're talking about potentially a few weeks of time between the initial diagnosis and getting those genomic profiling results, so we need to know how to talk to patients about the importance of taking the time to get this information, which is usually safe and appropriate to do in most clinical situations, and there may be some times where we need to make recommendations for empiric therapy before we have all of those answers back, and we need to know how and when to have those discussions as well.

Next, I think once we have those results, we have to know how to talk to our patients about what to expect. I think there has been a lot of optimism about the promise of checkpoint inhibitors and targeted therapies in patients with advanced lung cancer, but we need to keep those results in perspective. We're certainly doing a much better job of helping people to live better, longer lives, but the Holy Grail isn't quite a Holy Grail yet in terms of our ability to offer truly extended survival for many years and decades. For most patients, that's not the realistic outcome, even with these novel, exciting therapies, so one of the things that we're learning—and there are groups around the world, honestly, starting to look at studying this—is how do providers actually communicate realistically, honestly, but with appropriate optimism about what to expect when we use these therapies in our patients. I think that's another important area in which we need to refine our counseling strategies and our interactions with patients.

Announcer:

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