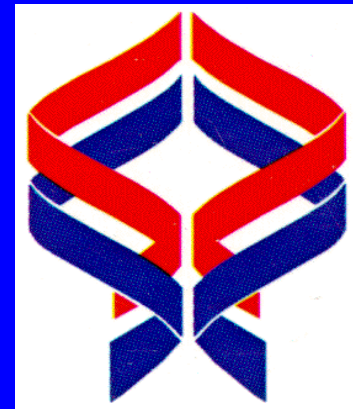


**2nd International Thoracic Oncology
Congress Dresden, 2010.**

Possible !

**Implications of the 7th Edition of
TNM for the Surgical Management
of Early Stage Lung Cancer**

**Peter Goldstraw,
Consultant Thoracic Surgeon,
Royal Brompton Hospital,
Professor of Thoracic Surgery,
National Heart and Lung Institute,
Imperial College, London, UK.**





INTERNATIONAL ASSOCIATION
FOR THE STUDY OF LUNG CANCER

Staging Manual in Thoracic Oncology



Peter Goldstraw, FRCS, Executive Editor

A Thoracic Oncology Reference Developed in Collaboration with the
 International Union Against Cancer
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Editorial Rx Press
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STAGING HANDBOOK IN THORACIC ONCOLOGY

IASLC

Available from www.iaslc.org

Improvements in the 7th Edition.

■ **Process of Revision:**

- **Both international bodies involved (AJCC/UICC).**
- **Through UICC, National TNM committees.**
- **Central role for the IASLC.**
- **Proposals published in Journal of Thoracic Oncology, 13 articles over 3 years.**

■ **Database:**

- **100,000 cases.**
- **46 sources in > 20 Countries.**
- **All modalities of care.**
- **Short accrual, stable staging algorithm.**

Improvements in the 7th Edition.

- **Data analysis:**
 - **Independent biostatisticians.**
 - Logic checks and minimum data set.
 - Massive computing power.
 - Newer statistical methods.
 - **International, multimodality committee.**
 - Clinical relevance.
 - **Rigorous validation process.**
 - Internal, consistent for all types of data base, consistent across globe.
 - External, supported by SEER data base.

Improvements in the 7th Edition.

However, the data base could not assess the validity of alternative treatment algorithms. Consequently any suggestions that changes in stage or category should lead to changes in treatment approaches require to be tested in appropriate clinical trials.

Of the changes in the 7th edition of TNM, which changes to T, N or M categories, or TNM stage groupings might imply changes to treatment algorithms, and are worth testing in a clinical trial?

Changes in 7e of TNM with possible implications for treatment decisions.

Additional size cut-points have been identified, sub-dividing some T categories, i.e. T1a/b, T2a/b and resulting in size becoming a T3 descriptor for the first time.

Should more limited surgery be considered in the best prognosis sub-group?

Should adjuvant therapy be considered in the worse prognosis sub-groups?

Changes in 7e of TNM with possible implications for treatment decisions.

**“some” of these cases always were!
Maybe those were the ones in our
data base? Maybe some were other
primaries? Does this prognosis apply
to just one nodule? or a few? or
only those in a “satellite” position?
Await prospective data collection.**

Changes in 7e of TNM with possible implications for treatment decisions.

**“zones” not “stations”,
“exploratory” analysis only,
pN data NOT cN,
Not validated,
Not adopted!
So many biases.**

**An old favourite amongst surgeons!
We will probably never get an answer!**

Changes in 7e of TNM with possible implications for treatment decisions.

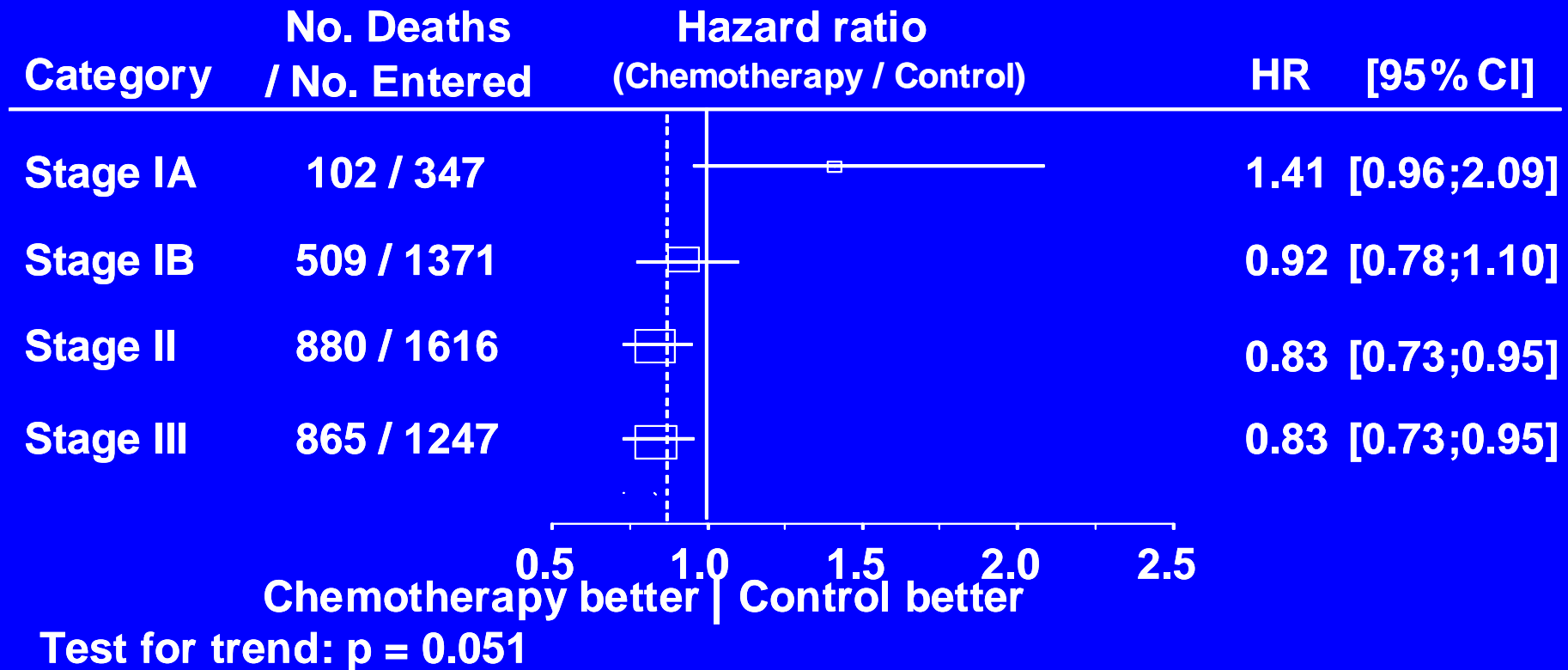
Large, node negative tumours are now stage II, i.e. tumours > 5cms are T2b, T2b N0 cases are IIA, and > 7cms tumours are T3, and T3 N0, stage IIB.

Should these cases receive adjuvant therapy after complete resection?

The data showing benefit for this was accrued when stage II was N1 disease.

LACE Meta-Analysis

- 4,584 pts from 5 phase III trials.
 - Cisplatin-based chemotherapy.
 - IALT, ALPI, BLT, JBR 10 and ANITA.



Changes in 7e of TNM with possible implications for treatment decisions.

Pre-operative selection of “resectable” T4 disease is always an issue and a very personal one. Nodal evaluation even more problematic. Both confounded by “induction” therapy.

Many resectable T4 cases are only identified at thoracotomy.

Support trials where possible.

Completeness of resection.

R0: Complete Resection.

All of the following are satisfied:

- a) Resection margins confirmed to be clear on microscopy.
- b) Six nodes/nodal stations removed/sampled for histological examination. These should include 3 nodes/stations from the mediastinum, one of which should be sub-carinal node #7 and 3 nodes/stations from the hilum or other N1 locations.

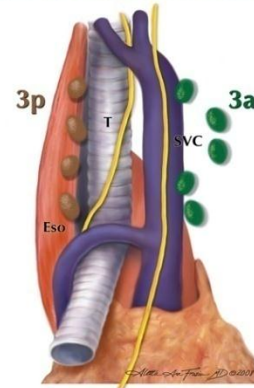
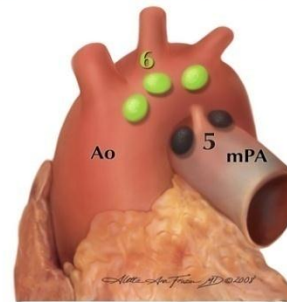
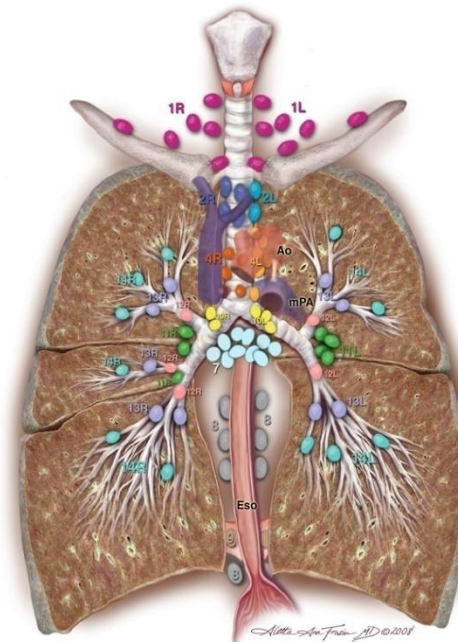
The IASLC nodal chart and table of definitions are now the recognised means of describing regional lymph node involvement in lung cancer.

IASLC Nodal Chart

Reconciled “Naruke”
and “Mountain/Dresler”
Nodal Charts.

“Oncologic” midline in
superior mediastinum
moved from the
anatomic midline.

Incorporating concept
of “Nodal Zones”.



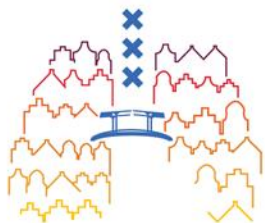
Supraclavicular zone
1 Low cervical, supraclavicular, and sternal notch nodes

SUPERIOR MEDIASTINAL NODES
Upper zone
2R Upper Paratracheal (right)
2L Upper Paratracheal (left)
3a Prevascular
3p Retrotracheal
4R Lower Paratracheal (right)
4L Lower Paratracheal (left)

AORTIC NODES
AP zone
5 Subaortic
6 Para-aortic (ascending aorta or phrenic)

INFERIOR MEDIASTINAL NODES
Subcarinal zone
7 Subcarinal
Lower zone
8 Paraesophageal (below carina)
9 Pulmonary ligament

N1 NODES
Hilar/Interlobar zone
10 Hilar
11 Interlobar
Peripheral zone
12 Lobar
13 Segmental
14 Subsegmental



14th World Conference
on Lung Cancer
IASLC

International Association for the Study of Lung Cancer



JULY 3 – 7, 2011

AMSTERDAM RAI, THE NETHERLANDS

14TH WORLD CONFERENCE ON LUNG CANCER



*Better Care through
Personalized Medical Approaches*

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