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Diagnosis of Advanced NSCLC Cancer Techniques in Clinical Practice

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Description

The landscape of care for advanced NSCLC has received much-needed hope thanks to developments in molecular diagnosis, therapy, and supportive care. There are now more effective chemotherapy regimens, molecularly targeted treatments, immune checkpoint inhibitor therapy, and evidence-based supportive care strategies available for treating a disease that previously had few therapeutic options for late-stage diagnoses. In fact, according to a recent study based on data from 2018, 67% of oncologists believed they had sufficient therapy options for patients with advanced lung cancer, up from 36% in 2008. Despite these advancements, maintaining functional status, reducing impairment, and enhancing patient resilience both during and after active therapy continue to be problems in clinical care for advanced NSCLC.

Making treatment recommendations based on functional state is probably less clear than ever now that molecularly targeted treatments and immune checkpoint inhibitors are available. These procedures might be less harmful and more efficient than traditional chemotherapy. Patients who in the past might not have been candidates for systemic therapy may now be able to tolerate and profit from these more recent treatments.

In their article, "Functional trajectories and resilience in persons with advanced lung cancer," Presley discusses the prognostic difficulties mentioned above. The prospective cohort study Beating Lung Cancer in Ohio's longitudinal data was used to generate the findings presented here. EQ-5D-5L patient assessments of functional status were conducted monthly for up to 8 months after diagnosis in 207 individuals with advanced NSCLC.

Presley examines these prognostic implications in their paper, "Functional trajectories and resilience in patients with advanced lung cancer." The author provides the complete longitudinal data from the prospective cohort study Beating Lung Cancer in Ohio. The functional status of 207 patients with advanced NSCLC was assessed monthly for up to 8 months following diagnosis using the EQ-5D-5L patient.

EQ-5D-5L patient-reported outcomes survey) were evaluated every month for up to 8 months after diagnosis in 207 patients with advanced NSCLC. Implying three distinct trajectories from these data, the researchers classified them as none/mild disability (38%), moderate disability (48%), and severe disability (14%). However, baseline Eastern Cooperative Oncology Group performance status (ECOG PS) >1, as well as certain worse physical (e.g., dyspnea, pain), and psychological (e.g., depressive, anxious) symptoms, were associated with the severe disability trajectory. Most demographic characteristics,

baseline presence of brain metastases, and treatment types were not statistically different across trajectory groups. After one month, the majority of participants (74%) showed functional resilience, which is defined as maintaining or improving the baseline EQ-5D-5L score. However, by month eight, whenever one of the samples had passed away, this percentage had dropped to 46%. The Presley study offers another tool for oncology doctors and patients to employ in making decisions about therapy and supportive care requirements, which has the potential to enhance the care of patients with advanced NSCLC.

As the authors point out, a physician might be able to think about and go over a more active treatment plan with a patient who is older but still capable of taking care of themselves and who reports few physical and mental symptoms. Physiological fitness, rather than chronological age, should be considered to assess treatment candidacy, which is a tenet of oncology practice. The study also broadens our comprehension of prognostic factors beyond the use of performance status assessments, which have come under fire for being unduly subjective, inconsistently performed, and insufficiently predictive of treatment outcomes. The study's overall conclusions may promote a more inclusive approach to advanced NSCLC treatment, in line with current demands to broaden the criteria for clinical trial eligibility and other lung cancer care-related issues.

Despite widespread anticipation for more accurate data to guide care for advanced NSCLC, we caution against using prognostic models as an excuse to completely forgo treatment. We understand the concerns about extending anticancer treatments past the point of no return. 6 We must keep in mind, though, that side effects from medical cancer therapies rarely present as sudden, fatal incidents. The adverse effects of medicinal cancer therapy reflect the longitudinal nature of these treatments, in contrast to the dangers of surgery, which are mostly embodied in same-day anesthesia considerations and near-term postoperative occurrences like infection and thrombosis. Over the course of months, toxicities develop and change, frequently giving clinicians several opportunities to change dose, timing, or supportive care regimens.

The cost of frequently completing and interpreting PRO assessments on patients and clinicians should also be taken into account in the actual world. Despite the fact that the data are useful and modern interpretive tools can simplify these methods, alert fatigue and the electronic health record in general have been identified as major contributors to physician burnout. In the future, it will be crucial to take into account the clinical logistics and perceived burden of use, in addition to the validity and generalizability of functional status trajectory instruments.