



Editorial

The Pulmonologist–Patient Relationship After the Lung Cancer Committee Decision[☆]



El neumólogo y su paciente tras la decisión del comité de cáncer de pulmón

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The role of the pulmonologist in the different stages of diagnosis and staging of lung cancer (LC) in routine clinical practice is well recognized. Clinical data and endoscopic tests provide essential technical information that allows multidisciplinary tumor committees to evaluate the individual situation of each patient. Furthermore, knowledge of the more personal aspects of the patient's socio-cultural views and their opinions on the various treatment alternatives, etc., in the context of a disease that often challenges one's perception of life, creates an important bond between the patient and the pulmonologist: the patient comes to consider us as their physician of reference, while we get to know them as an individual person. Is it reasonable, then, that after the committee meeting, at such a transcendental point in that person's life, we lose all contact with our patient? Are we prepared to maintain the relationship?

The contact does continue in some situations. For example, we are responsible for the management of complications from the various treatments or earlier comorbidities. However, we need to reflect more deeply on how to maintain the ties and commitments that we have established with our patients. Our first task after receiving the personalized evaluation of the tumor committee will be to explain the advised course of treatment to our patient. The information to be transmitted is particularly sensitive for individuals with more advanced disease or whose physical conditions do not meet the required criteria for curative treatment. During this visit, we must transmit the specific, up-to-date technical details appropriate to the situation in an appropriately personal manner. Therapeutic advances are occurring very rapidly in different fields, sometimes leading to some degree of disorientation; in this case, the updated information offered by the websites of highly prestigious organizations can be of particular help.^{1,2} For patients who are candidates for chemotherapy, this may be the time to highlight the potential benefits, which may offer some hope. We should remember that currently about 50% of patients with a diagnosis of advanced non-small cell LC may be suitable candidates for some of

the new therapies associated with the presence of specific genetic changes (positive EGFR mutations in 16% of cases,³ ROS1 in 1%,⁴ ALK rearrangements in 4%–6%⁵), or with significant PDL1 expression, detected in up to 30% of patients,⁶ with the consequent benefits in terms of survival and quality of life. In the dwindling number of patients with a high comorbidity burden or poor general condition who will receive palliative care only, we must maintain, and if possible bolster, our role in their care. Evidence shows that early, well designed interventions administered in collaboration with specialists in primary or palliative care have shown improvements in survival, psychological factors, and quality of life.⁷

These patients can also be offered cancer care and chemotherapy in the respiratory medicine department. This remains the approach in some centers in Spain, and is one of the official competency areas addressed in specialist training programs.⁸ It is also included in the HERMES project of the ERS⁹ and has been addressed in this journal.¹⁰ The future development of new, more personalized therapies that are easier to administer will offer an opportunity for pulmonologists to reignite their interest in the treatment of cancer patients and the provision of integral care.

Should our LC patients be followed up in respiratory medicine clinics? In practice, most patients with advanced small cell and non-small cell tumors are almost exclusively seen by oncologists and/or radiologists. Patients who have undergone surgery are followed up in order to promptly identify recurrences and second primary tumors, even though the possibility of curative treatment is limited, and the impact of post-surgical surveillance on survival has been questioned.¹¹ Although surveillance may influence outcomes and is recommended by the major scientific societies,^{1,12} it seems that in our setting it is conducted in scarcely half of all cases.¹³ It seems advisable, then, to follow up patients, to work in partnership with thoracic surgeons and oncologists, and to stay abreast of new methodologies. A French study of collaboration between oncologists and pulmonologists in patients with advanced LC¹⁴ showed benefits in survival attributable to a closer clinical surveillance supported by information technology resources. We also trust that the use of blood and breath biomarkers will be feasible, and that these techniques will ultimately complement or even replace the potentially harmful radiological procedures used today.¹¹

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Another technique gaining prominence is rebiopsy of metastatic lesions or recurrent advanced LC to determine conversion to other histologies, and in particular, to identify the status of genetic mutations associated with good response to next-generation tyrosine kinase inhibitors.¹⁵ Advances in the study of genetic alterations in tissues or biological fluids (liquid biopsy) will lead to the development of new tumor-specific therapies and, in all likelihood, more personalized treatments that differ from the chemotherapy we know today.

In my opinion, we can, and must, maintain a relationship with a good many of our LC patients after they are assessed by the tumor committee. We can work with thoracic surgeons, oncologists, radiologists, and other professionals in order to achieve our ultimate goal: the wellbeing of the patient. And of course, we, as pulmonologists, must maintain a high level of training, both in the areas traditionally assigned to us, and in surveillance strategies and use of the best techniques (palliative care, rebiopsies). We must also keep up-to-date with novel treatments or medications – indeed, the future therapeutic arsenal will most probably be akin to other therapies already used in respiratory medicine for the treatment of fibrosis and pulmonary hypertension. But all this, of course, will depend entirely on our willingness to embrace these responsibilities.

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