Guidelines for the Management of Lung Cancer

Quick Reference Version
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Guidelines for the Management of Lung Cancer

Presentation
Lung cancer is the third most common cancer in Canada, and the leading cause of cancer deaths. Patients with lung cancer may present with various symptoms, which mimic other pulmonary disorders, and often mimic the 'smoker's cough' that precedes cancer in many smokers. Typically, a change in pulmonary symptoms is the most suspicious sign of lung cancer. Common presenting symptoms include cough, chest pain, rust-coloured or purulent sputum, hemoptysis or dyspnea. Some patients may present without clinical symptoms, just an abnormal chest x-ray. These patients often have the best prognosis, and careful evaluation and follow-up of these patients is crucial.

Management
Management of lung cancer begins with referral from the family physician to the local surgeon or surgical oncologist for appropriate surgery (for patients who are reasonable surgical candidates with early stages of the disease). Patients who have hemoptysis, a change in their cough, or persistent pneumonia, require further investigations for malignancy. Clinical staging of non-small cell lung cancer is integral to management decisions. Staging may be achieved during surgical resection (for continuing management decisions in earlier stage cancers), or may be achieved by clinical examination and diagnostic imaging (for more advanced disease). Radiation therapy and/or chemotherapy may be considered for initial treatment or later if the cancer relapses. Small cell lung cancer is generally split into limited or extensive stages, based upon the clinical decision of the radiation oncologist. Staging is a clinical decision, not based upon disease pathology.

Supportive care of lung cancer patients can be as important as managing the tumour. Local management of bronchial obstruction, superior vena cava (SVC) syndrome and dyspnea may be achieved through good tumour control. Other cancer-related symptoms also require good management as they occur. For information on management of symptoms and distress, please visit the Cancer Care Nova Scotia website (www.cancercare.ns.ca) for appropriate supportive care guidelines.

Guidelines
To follow the guideline care pathways in the following pages, begin with the staging of a patient, then go to the appropriate treatment page(s) for the stage of disease. Recurrences, metastases and surveillance are also discussed in the pages noted below. Management of non-small cell lung cancer precedes management of small cell lung cancer in these care pathways.

Practice guidelines are intended to assist health care professionals with decisions throughout the spectrum of the cancer experience. Guidelines should never replace specific decisions for individual patients, and do not substitute for the shared decisions between any patient and doctor (or other health professional) which are unique to each circumstance. However, guidelines do provide evidence-based background information, consensus-based recommendations for similar problems, and a context for each individual decision. A full-text version of this guideline is also available on the Cancer Care Nova Scotia website. Both versions of this guideline will be revised, from time to time, as new evidence becomes available.

1 - For the Full Version, see the Cancer Care Nova Scotia website at www.cancercare.ns.ca
**Diagnosis and Referral of Lung Cancer - Overview**

### Signs & symptoms of Lung Cancer
- Identified by Primary Care Physician
- Consider performance status & weight loss in patient evaluation

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**Chest X-ray**
(Include review of old X-ray films)

- **Normal or no lesion**
  - Referral to surgeon, or lung specialist (Suspicion of lung cancer)

- **Lesion or abnormality**
  - For other investigations, see Page 3

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**Referral to surgeon or lung specialist for evaluation**

**AND**

- Additional radiological imaging (Urgent CT)

- **SCLC or inoperable NSCLC**
  - Pathology Review: Confirm histology and/or cytology

- **Resectable NSCLC**
  - Pathologic Evaluation (staging)

  - Resection if indicated

  - OR

  - Referral to: Medical Oncology, Radiation Oncology, Internal Medicine, Palliative Care as appropriate

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**Footnotes:**
- a. ECOG Performance Status criteria - See Page 19
- b. Referral to local thoracic surgeon or thoracic surgical oncologist at Cancer Centre
- c. Clear boxes may be performed by family doctor; grey boxes will occur at the hospital with a cancer care program

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See Treatment for each stage (Pages 6 to 17)

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Investigations for the Diagnosis and Staging of Lung Cancer

Referral Information:
A letter of referral is the minimal requirement for a referral. A referral need not be delayed due to delays in scheduling tests or delayed reporting of tests.

QEI Health Sciences Centre:
- Fax referrals to the Nova Scotia Cancer Centre Referrals Office at 902-473-6079 (tel. 902-473-6050 or 902-473-6098).
- For urgent referrals, page the appropriate specialist on call through the Locating service (902-473-2220).

Cape Breton Cancer Centre:
- Direct referrals to the Referrals/Booking office at 902-567-7774 (fax 902-567-7911).
- For urgent referrals, page the appropriate specialist on call through the Locating service (902-567-8000).

Referral Information:
- Letter of Referral*
- Pathology Reports*
- Operative Reports (relevant to the cancer)*
- Diagnostic Imaging Reports*
* Specific information which is necessary for proper triage of referrals

Investigations for Lung Cancer
- Pathology Review
- History & Physical (include performance status + weight loss)
- Chest X-ray
- CT scan of chest and upper abdomen (including adrenal glands)
- CBC, Serum chemistry profile
- Pulmonary Function Tests
  May be performed by the Primary Care physician or referred to be done by the lung cancer specialist

May be arranged by lung cancer specialist

Assess for pain & symptoms, distress, and other psychosocial needs throughout continuum of care (diagnosis to treatment to follow-up)
Address supportive care needs as they are identified

For clinical staging of Small Cell Lung Cancer, see Page 15

For clinical staging of Non-Small Cell Lung Cancer, see Page 4

Symptomatic for brain mets

Symptomatic for bone mets or elevated alk phos

For Treatment of Metastatic Lung Cancer, see Page 14 for NSCLC or Page 16 for SCLC

For urgent referrals, page the appropriate specialist on call through the Locating service (902-473-2220).

Referral Information:
Letter of Referral*
Pathology Reports*
Operative Reports (relevant to the cancer)*
Diagnostic Imaging Reports*
* Specific information which is necessary for proper triage of referrals

Brain scan
Bone scan

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### Staging of Non-Small Cell Lung Cancer - TNM Staging Diagram

#### Primary Tumour (T)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Endo-bronchial location</th>
<th>c. Local invasion</th>
<th>d. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>T4 (a &amp; c) or d</td>
<td>b.</td>
<td>Mediatinum/ trachea/ heart/ great vessels/ esophagus/ vertebral body/ carina</td>
<td>Malignant pleural/pericardial effusion or satellite tumour nodule(s) within the ipsilateral primary-tumour lobe</td>
</tr>
<tr>
<td>T3 (a &amp; c) or b or d</td>
<td>any Main bronchus (&lt; 2cm distal to the carina)</td>
<td>Chest wall (incl. superior sulcus tumour)/ diaphragm/ mediastinal pleura/ perietal pericardium</td>
<td>Atelectasis/ obstructive pneumonitis of the entire lung</td>
</tr>
<tr>
<td>T2 any of a, b, c, d</td>
<td>any Main bronchus (&gt; 2cm distal to the carina)</td>
<td>Visceral pleura</td>
<td>Atelectasis or obstructive pneumonitis that extends to the hilar region but does not involve the entire lung</td>
</tr>
<tr>
<td>T1 a &amp; b &amp; c</td>
<td>&gt; 3cm No invasion proximal to the lobar bronchus</td>
<td>Surrounded by lung or visceral pleura</td>
<td>—</td>
</tr>
</tbody>
</table>

#### Lymph Node (N)

- a. Peribronchial (ipsilateral)
- b. Hilar (ipsilateral)
- c. Mediastinal (ipsilateral)
- d. Subcarinal
- e. Hilar (contralateral)
- f. Mediastinal (contralateral)
- g. Scalene (ipsi/contralateral)
- h. Supraclavicular

#### Stage 0

- Tis: Carcinoma in situ

Staging is not relevant for Occult Carcinoma (TX, N0, M0)

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Staging of Non-Small Cell Lung Cancer - Nodal Status

REGIONAL NODAL STATIONS FOR LUNG CANCER STAGING

**N1 Nodes**
(outside mediastinal pleura)
- Hilar (ipsilateral)
- Interlobar
- Lobar
- Segmental
- Subsegmental

**DIAGRAM 2**

**N2 Nodes**
(inside mediastinal pleura)
- Superior Mediastinal Nodes (ipsilateral)
  - Highest mediastinal
  - Upper Paratracheal
  - Pre- and Retrotracheal
  - Lower Paratracheal (including Azygos Nodes)
- Aortic Nodes
  - Subaortic (A_P Window)
  - Para-aortic (ascending aorta or phrenic)
- Inferior Mediastinal Nodes (ipsilateral)
  - Subcarinal
  - Paraesophageal (below carina)
  - Pulmonary Ligament

**DIAGRAM 3**

**N3 Nodes**

- Supraclavicular (other side)
- Contralateral nodes
- Tumor

**Diagram 4**

For the Full Version, see the Cancer Care Nova Scotia website at www.cancercare.ns.ca
Treatment of Non-Small Cell Lung Cancer—Clinical Stage I & IIA

Stage I
(T1-2, N0)
Stage IIA
(T1-2, N1)

- Bronchoscopy
- CT scan of chest/upper abdomen
- Mediastinoscopy (at discretion of surgeon)
- See Page 2 for other investigation(s)

Assess for pain & symptoms, distress, and other psychosocial needs
Address supportive care needs as they are identified

Stage I
(T1-2, N0)

Stage IIA
(T1-2, N1)

 Bronchoscopy
CT scan of chest/upper abdomen
Mediastinoscopy (at discretion of surgeon)
See Page 2 for other investigation(s)

Margins positive (R1, R2)* OR
Positive mediastinal nodes
Refer to Radiation Oncology (OR consider re-resection)
Referral to Medical Oncology (high risk Stage IB-II NSCLC) for adjuvant chemotherapy

Margins negative (R0)*
Refer to Radiation Oncology and/or Medical Oncology
See Surveillance—Page 13

Assess for pain & symptoms, distress, and other psychosocial needs
Address supportive care needs as they are identified

Footnote: a. R0 = no residual tumour, R1 = microscopic residual tumour,
R2 = macroscopic residual tumour
Treatment of Non-Small Cell Lung Cancer - Clinical Stage IIB & IIIA

**Stage IIB**
(T3, N0)

**Stage IIIA**
(T3, N1)

- Bronchoscopy
- CT chest/upper abdomen
- MRI of spine & thoracic inlet for superior sulcus lesions as indicated
- See Page 2 for other investigation(s)

**Deemed resectable**

- Pre-op Chemo-radiotherapy (superior sulcus tumour)
- Surgery

**Deemed unresectable**

- Observe
- Chemo-radiotherapy OR Radiotherapy

**Assess for pain & symptoms, distress, and other psychosocial needs**
**Address supportive care needs as they are identified**

**Margins negative (R0)\(^a\)**

- Consider surgery (if resectable)

**Margins positive (R1,R2)\(^a\)**

- Observe
- Positive mediastinal nodes

- Referral to Radiotherapy (OR consider Re-resection)

**Margins negative (R0)\(^a\)**

- Observe

Stage IIB and IIIA - Examples

**Stage IIB (T3,N0-2,M0)**
Superior sulcus tumor with or without lymph node involvement

**Stage IIIA (T3,N1,M0)**
Peripheral tumor >3cm involving chest wall and hilar lymph nodes

Footnote:
\(a\). R0 = no residual tumour, R1 = microscopic residual tumour,
R2 = macroscopic residual tumour

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Stage IIIA (T1-3, N2) (cont'd)

- CT chest/ upper abdomen
- Bronchoscopy
- Mediastinoscopy
- See Page 2 for other investigations

Assess for pain & symptoms, distress, and other psychosocial needs
Address supportive care needs as they are identified

Mediastinal Biopsy
Findings

Positive N2
Chemotherapy and/or Radiotherapy
Observe

Negative N2, N3
See Treatment Stage I & II-Page 6

Diagram 8.

Stage IIIA - Example

T3,N2,N9
Involvement of ipsilateral hilar and mediastinal lymph nodes

Guidelines for the Management of Lung Cancer- Quick Reference Version - 8
Treatment of Non-Small Cell Lung Cancer - Clinical Stage IIIB

Stage IIIB (T4, N0-1)

- Bronchoscopy
- CT scan of chest/upper abdomen
- Consider Mediastinoscopy
- See Page 2 for other investigations

Potentially Resectable

Consider pre-operative Chemotherapy and/or Radiotherapy

Reassess resectability

Surgery

Margins negative (R0)\(^a\)

Margins positive (R1,R2)\(^a\)

Observe

Not resectable upon surgical exploration

Unresectable

Referral for Radiotherapy and/or Chemotherapy

Assess for pain & symptoms, distress, and other psychosocial needs
Address supportive care needs as they are identified

---

Footnote:
\(^a\) R0 = no residual tumour, R1 = microscopic residual tumour, R2 = macroscopic residual tumour

---

Stage IIIB - Example

T4,N1,M0
Involving pleural membrane and ipsilateral hilar nodes (with pleural effusion)

Pleural effusion

Diagram 9.
Guidelines for the Management of Lung Cancer - Quick Reference Version

Treatment of Non-Small Cell Lung Cancer - Clinical Stage IIIB (cont'd)

Stage IIIB (T1-3, N3)

Pathologic confirmation of N3 disease by:
- Mediastinoscopy
- Supraclavicular lymph node biopsy
- Thoracoscopy
- Needle biopsy
- Mediastinoscopy

N3 Nodes

Negative

See treatment of Stage I-III A - Pages 6-8

Positive

Brain MRI
Bone Scan

Negative

Chemotherapy/Radiotherapy

Positive

See treatment of metastatic disease - Page 14

Assess for pain & symptoms, distress, and other psychosocial needs
Address supportive care needs as they are identified

Diagram 10.

Stage IIIB - Example

T3, N3, M0
Involving pericardium and both ipsilateral nodes (N1, 2) and contralateral nodes (N3)

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Treatment of Non-Small Cell Lung Cancer-
Clinical Stage IIIB (cont'd)

Stage IIIB (T4, N2-3)

Pathologic confirmation of T4, N2-3 disease by:
- Mediastinoscopy
- Supraclavicular lymph node biopsy
- Thoracoscopy
- Needle biopsy
- Mediastinoscopy
- Bone scan
- Brain MRI

N3 Nodes

Ipsilateral Node Negative → N0

Contralateral Node Negative

Contralateral Node Positive

Ipsilateral Node Positive

Chemotherapy/Radiotherapy

Chemotherapy/Radiotherapy

Assess for pain & symptoms, distress, and other psychosocial needs
Address supportive care needs as they are identified

See treatment of Stage IIIB T4, N0-1 - Page 7

Diagram 11.

Stage IIIB - Example

T4,N3,M0 Involving great vessels, ipsilateral and contralateral lymph nodes with satellite ipsilateral nodule

11 - For the Full Version, see the Cancer Care Nova Scotia website at www.cancercare.ns.ca
Guidelines for the Management of Lung Cancer - Quick Reference Version

Treatment of Non-Small Cell Lung Cancer - Clinical Stage IIIB & IV

**Stage IIIB**  
(T4: pleural effusion)

Thoracentesis +/- thoracoscopy if thoracentesis indeterminate

*Referral for Chemotherapy and/or Radiotherapy*

If Positive\(^a\)

- Local therapy if necessary (e.g. pleurodesis)

**Stage IV**  
(M1: solitary site)

Pathologic & clinical confirmation of M1 disease by:
- Mediastinoscopy
- Bronchoscopy
- Bone scan
- Brain MRI
- CT scan of chest and upper abdomen (including adrenal glands)

**Brain**

Consider MRI or pathologic diagnosis

Referral for Radiotherapy and/or Chemotherapy

**Adrenal**

Referral for Radiotherapy and/or Chemotherapy

Assess for pain & symptoms, distress, and other psychosocial needs

Address supportive care needs as they are identified

**Stage IV**  
(M1: disseminated)

Referral for Radiotherapy and/or Chemotherapy

See treatment of recurrence and metastasis (Pages 32,33)

Footnote:

\(^a\) Most pleural effusions associated with lung cancer are due to tumour. There are few patients in whom multiple cytopathologic examinations of pleural fluid are negative for tumour. Fluid is non-bloody and not an exudate. When these elements and clinical judgement dictate the effusion is not related to the tumour, the effusion should be excluded as a staging element and the patient should be staged T1, T2 or T3.
Surveillance and Treatment of Recurrent Non-Small Cell Lung Cancer

**Surveillance**

- In asymptomatic patients, clinical assessment + chest X-ray every 6 mo for 3 yr, then annually
- Smoking cessation counselling

**Locoregional recurrence:**
- Endobronchial obstruction:
  - External-beam Radiotherapy
  - Laser/stent/other surgery
  - Brachytherapy
- Resectable local recurrence:
  - Re-resection
  - External-beam Radiotherapy
- Superior vena cava (SVC) obstruction:
  - External-beam Radiotherapy
  - Stent
- Severe hemoptysis:
  - Bronchoscopy (to assess for intervention)
    - External-beam Radiotherapy
    - Brachytherapy
    - Laser
    - Embolization
    - Surgery

**Evidence of disseminated disease**

See treatment of recurrence and metastasis (Page 14)

**Solitary metastasis**

See treatment of recurrence and metastasis (Page 14)

**Diagram 13.**

Assess for pain & symptoms, distress, and other psychosocial needs
Address supportive care needs as they are identified

Lung Cancer Recurrence - Examples

- Obstructed bronchus
- Brain metastasis
- Bone or spinal metastasis
- SVC syndrome

For the Full Version, see the Cancer Care Nova Scotia website at www.cancercare.ns.ca
Guidelines for the Management of Lung Cancer - Quick Reference Version

Treatment of Non-Small Cell Lung Cancer - Metastases

**Performance status 0-2^a,b**

- **Chemotherapy** (usually 2 cycles)
- **Best supportive care**
  - See CCNS Guidelines for management of specific symptoms, where appropriate

**Response or stable disease**

- **Consider chemotherapy**
- Observation

**Progression**

- **Response or stable disease**
- **Consider 2 more cycles chemotherapy** (total of 6 cycles)
  - See below for salvage treatment

**Referral to Medical and/or Radiation Oncology**

**Observation**

**Relapsed Non-Small Cell Lung Cancer**

**Relapsed disease**

- **Consider chemotherapy**
  - **OR**
  - **Consider Radiotherapy**
  - **OR**
  - **Clinical trial**
  - **OR**
  - **Observation**

**Relapse performance status^a, 3, 4**

- **Best supportive care**
- **Consider chemotherapy**
- **OR**
- **Best supportive care**
- **OR**
- **Phase I/II clinical trial**

**Assess for pain & symptoms, distress, and other psychosocial needs**

**Address supportive care needs as they are identified**

Footnotes:

a. ECOG Performance Status criteria - See Page 19
b. Performance status (PS) 2 patients have greater toxicity and potential for lower benefit than PS 0-1 patients
Staging of Small Cell Lung Cancer

Referral to Medical Oncology

Clinical Staging for Small Cell Lung Cancer

Limited Stage
- Disease in hemithorax only AND
- Can be encompassed within a reasonable radiation port (assessed by radiation oncologist)

Additional evaluations:
- MRI or CT scan of the head
- Bone scan

Negative findings

Positive findings

See treatment of extensive stage disease (Page 16)

Limited Stage
- Disease in contralateral lung AND/OR
- Pleural Effusion AND/OR
- Any disseminated disease

Extensive Stage

See treatment of limited stage disease (Page 16)

Assess for pain & symptoms, distress, and other psychosocial needs
Address supportive care needs as they are identified

NOTE: SCLC can be staged using the same TNM Staging criteria applied to NSCLC; however, clinicians generally use the simpler classification of Limited vs. Extensive Disease. Treatment decisions are usually based upon this simple classification system.
Treatment of Small Cell Lung Cancer

**Initial Treatment**

**Limited disease**
- Chemotherapy + concurrent Radiotherapy
  - Responder
  - Prophylactic Cranial Irradiation

**Extensive stage**
- Severe debilitation
  - Consider chemotherapy and/or palliative radiotherapy and/or best supportive care

**Extensive stage** + other localized symptomatic sites (e.g. bone, spinal cord)
- Spinal cord involvement
  - Radiotherapy and chemotherapy

**Extensive stage** + brain metastasis
- Consider chemotherapy +/- whole brain radiotherapy

Assess for pain & symptoms, distress, and other psychosocial needs
Address supportive care needs as they are identified

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**Footnote:**
a. Radiotherapy for limited disease:
- Radiotherapy over 3-5 weeks concurrent with chemotherapy
- Prophylactic Cranial Irradiation (PCI) treatment over about 2 weeks
**Follow-up after Treatment of Small Cell Lung Cancer**

### Response Assessment Following Initial Treatment
- **History & physical exam** (including weight loss)
- **Chest X-ray**
- **Consider CT scan of chest** (baseline post-treatment)

**Complete response or radiation scarring on chest imaging studies**

**Partial response**

**Progressive disease or relapse**

- Assess for pain & symptoms, distress, and other psychosocial needs
- Address supportive care needs as they are identified

**See below**

### Oncology follow-up visits every 3-6 mo for 2 yr, then every 6-12 mo
- New pulmonary nodule after 2 yr follow-up should initiate work-up for potential new primary
- At every visit: H&P, chest X-ray, bloodwork as clinically indicated
- Smoking cessation counselling

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### Relapsed or Progressive Small Cell Lung Cancer

**Consider second-line chemotherapy and/or palliative radiotherapy**

**Relapse or refractory to second-line therapy**

**Best supportive care**

**Consider third-line chemotherapy**

**OR**

**Best supportive care**

**See CCNS Guidelines for management of specific symptoms, where appropriate**

**Assess for pain & symptoms, distress, and other psychosocial needs**
**Address supportive care needs as they are identified**
### Chemotherapy Regimens

#### Non-Small Cell Lung Cancer

**Docetaxel Chemotherapy**
- Docetaxel IV- Day 1
- Repeat every three weeks

**Docetaxel-Carboplatin Chemotherapy**
- Docetaxel IV- Day 1
- Carboplatin IV- Day 1
- Repeat every three weeks

**Docetaxel-Cisplatin Chemotherapy**
- Docetaxel IV- Day 1
- Cisplatin IV- Day 1
- Repeat every three weeks

**Docetaxel-Gemcitabine Chemotherapy**
- Docetaxel IV- Day 1
- Gemcitabine IV- Days 1, 8, and 15
- Repeat every three weeks

**Gemcitabine-Cisplatin Chemotherapy**
- Gemcitabine IV- Days 1, 8, and 15
- Cisplatin IV- Day 1
- Repeat every four weeks

**Paclitaxel-Carboplatin Chemotherapy**
- Paclitaxel IV over 3 hours- Day 1
- Carboplatin IV- Day 1
- Repeat every three weeks

**Paclitaxel-Cisplatin Chemotherapy**
- Paclitaxel IV over 3 hours- Day 1
- Cisplatin IV- Day 1
- Repeat every four weeks

**Paclitaxel-Carboplatin Chemotherapy**
- Paclitaxel IV over 3 hours- Day 1
- Carboplatin IV- Day 1
- Repeat every four weeks

**Vinblastine-Cisplatin Chemotherapy**
- Vinblastine IV- Days 1, 8, 15 & 22
- Cisplatin IV- Day 1
- Concurrent with radiotherapy

**Vinorelbine-Carboplatin Chemotherapy**
- Vinorelbine IV- Days 1, 8, 15 & 22
- Carboplatin IV- Day 1
- Repeat every four weeks

**Vinorelbine-Cisplatin Chemotherapy**
- Vinorelbine IV- Days 1, 8, 15 & 22
- Cisplatin IV- Day 1
- Repeat every four weeks

**Vincristine-Cisplatin Chemotherapy**
- Vincristine IV- Days 1, 8, 15 & 22
- Cisplatin IV- Day 1
- Repeat every four weeks

**Vinorelbine Chemotherapy**
- Vinorelbine IV- Days 1 & 8
- Repeat every 3 weeks

**CAV Chemotherapy**
- Cyclophosphamide IV- Day 1
- Doxorubicin IV- Day 1
- Vincristine IV- Day 1
- Repeat every three weeks for 4 cycles

**Etoposide Chemotherapy**
- Etoposide PO- daily for 14-21 days

**Topotecan Chemotherapy**
- Topotecan IV- Days 1-5
- Repeat every three weeks for 4 cycles

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**ECOG Performance Status Scale**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully active, able to carry on all predisease activities without restriction. (Karnofsky 90-100)</td>
</tr>
<tr>
<td>1</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, for example, light housework or office work. (Karnofsky 70-80)</td>
</tr>
<tr>
<td>2</td>
<td>Ambulatory and capable of all self-care but unable to carry out work activities. Up and about more than 50% of waking hours. (Karnofsky 50-60)</td>
</tr>
<tr>
<td>3</td>
<td>Capable of only limited self-care, confined to bed or chair 50% or more of waking hours. (Karnofsky 30-40)</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled, cannot carry on any self-care, totally confined to bed or chair. (Karnofsky 10-20)</td>
</tr>
</tbody>
</table>

ECOG = Eastern Cooperative Oncology Group

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NB. The role of EGFR Inhibitors (e.g. Erlotinib, Geftinib) are under review by the Thoracic CST

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See the [Systemic Therapy Manual for Cancer Patients](#) for further details.
Lung Cancer Prognosis by Stage

Diagram 15.

Diagram 16.

Diagrams 15 & 16.
Relative survival rates for lung cancer in males (15) and females (16) diagnosed in Nova Scotia in 1992 to 1996. Cases classified as local, regional or distant (not by the TNM staging classification), for comparison across different cancer types.
- Approximately 85% of lung tumours were non-small cell lung cancer.
- At diagnosis, 29% of lung cancers were advanced stage.

Reference:

19 - For the Full Version, see the Cancer Care Nova Scotia website at www.cancercare.ns.ca