

INTEGRATE 7.0

QUALI ‘REGOLE’ NELLA GESTIONE INTEGRATA DELLA NEOPLASIA POLMONARE?

GAMES

VERONA

13-14 OTTOBRE 2025

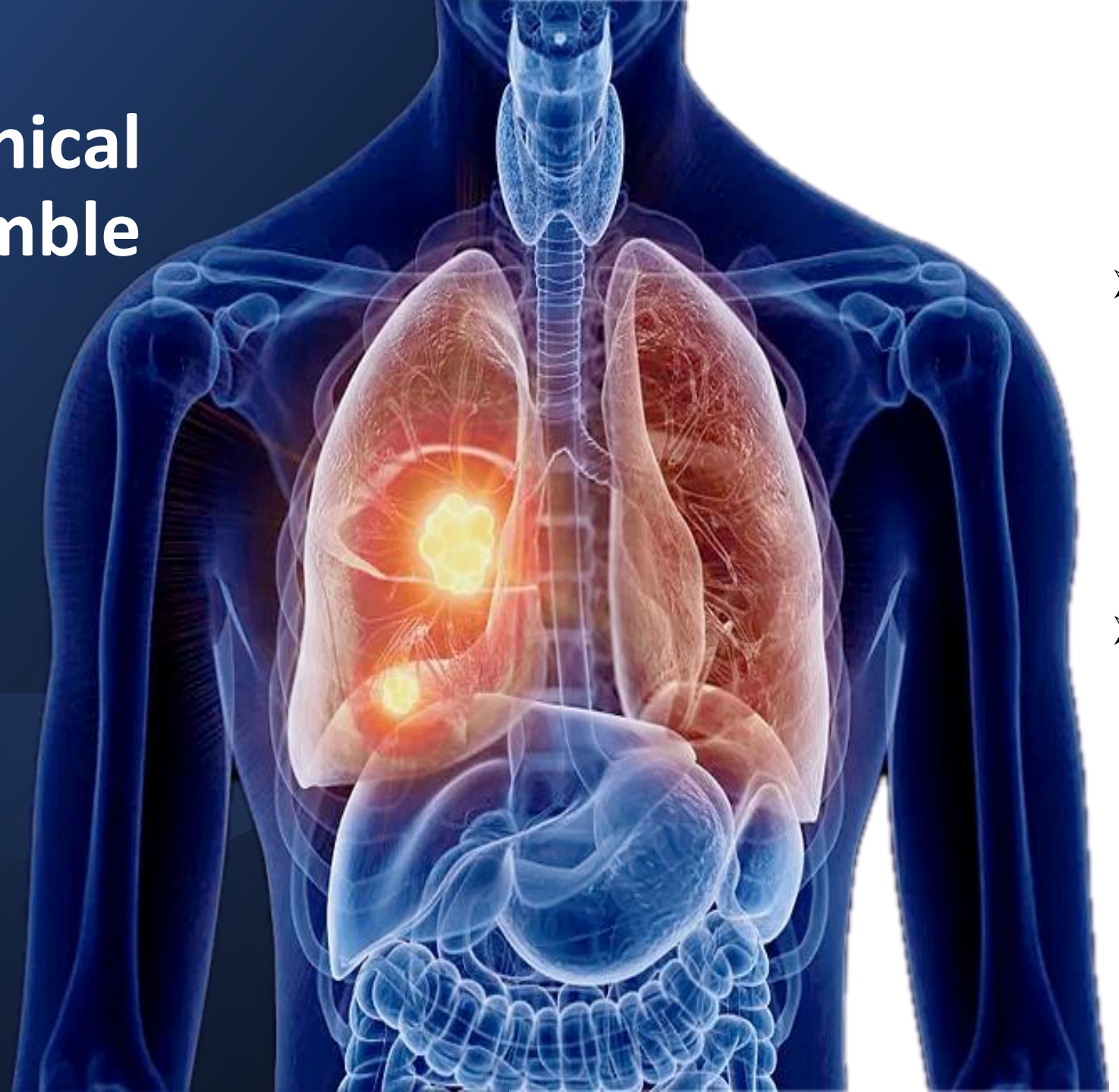
Stage III EGFR-mutant NSCLC

WHY SURGERY?



EVEN WITH A RIGHT PNEUMONECTOMY ON THE TABLE?

The Clinical Preamble



- **Stage III EGFRm NSCLC =** heterogeneous; cure requires optimal **local** + **systemic control**

- **EGFR TKIs revolutionize** adjuvant (**resected**) and consolidation (**unresectable**) settings

The Clinical Preamble



- **cT2bN2M0** EGFR del19; right lower-lobe, **multi-station N2**; **MDT** flagged **pneumonectomy risk**.

- **Attempt parenchyma-sparing** resection with a clear plan to **proceed** to **right pneumonectomy** if needed to achieve **R0**, then **adjuvant osimertinib**.

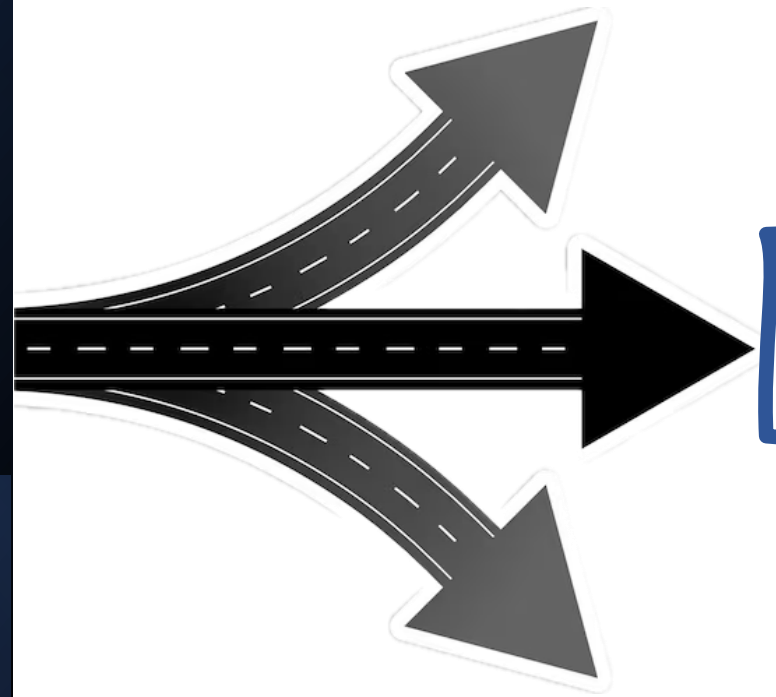
RIGHT PNEUMONECTOMY!?!





The crossroads

NOT SURGERY ALONE



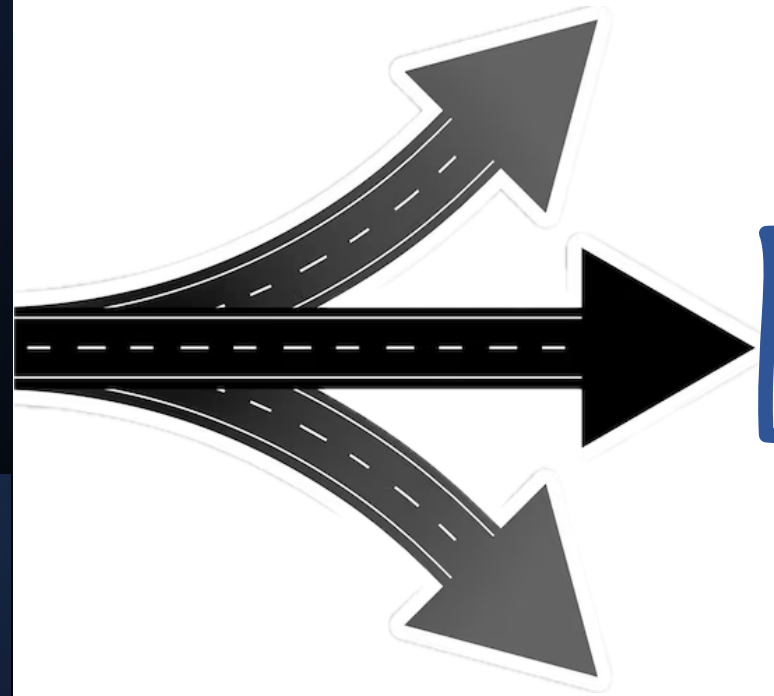
Non-pneumonectomy (lobectomy/sleeve/bilobectomy feasible)

Achieve **complete macroscopic clearance** + targeted **<u>adjuvant therapy</u>**

Right pneumonectomy needed (fit pt., R0 achievable)

The crossroads

Non-pneumonectomy (lobectomy/sleeve/bilobectomy feasible)



Achieve **complete macroscopic clearance** + targeted **adjuvant therapy**

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SURGERY !

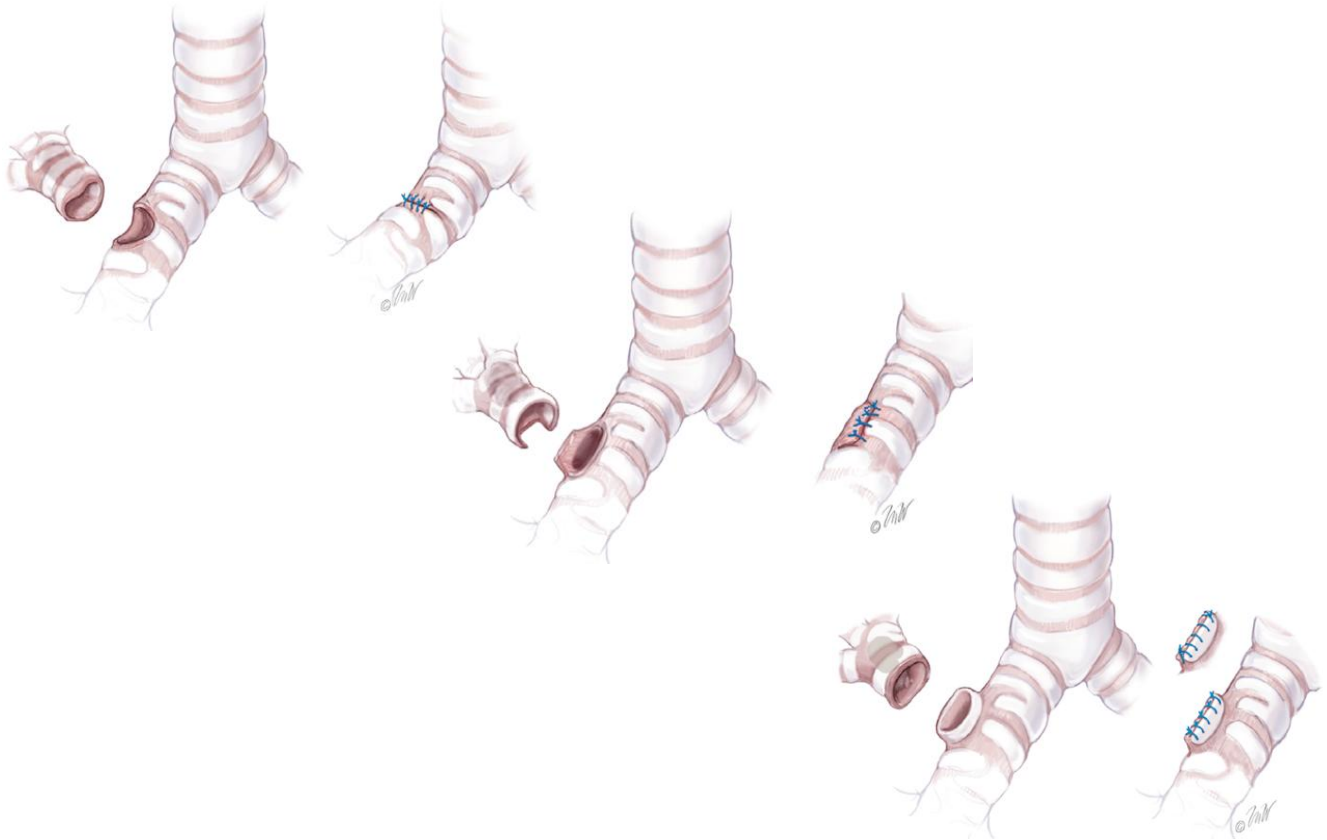
Achieve **complete macroscopic clearance** + targeted **adjuvant therapy**



Strategies to avoid pneumonectomy

PARECHYNA SPARING RO PAIRS PERFECTLY WITH ADJUVANT OSIMERTINIB

Consider **sleeve lobectomy /bilobectomy / bronchoplastic** resections for central tumors



R0
Low probability of occult distant metastases *(oncological resectability)*



Free resection margins (macro and microscopic) at the bronchial, peribronchial tissue, vascular (venous and arterial), and any peripheral or adjacent organ resected tissue

Anatomic resection (segment, lobe, bilobe, lung –**PNEUMONECTOMY-**)

Systematic or lobe-specific **nodal dissection** including at least **6 node stations** (3 hilar and **3 mediastinal including No. 7**)*

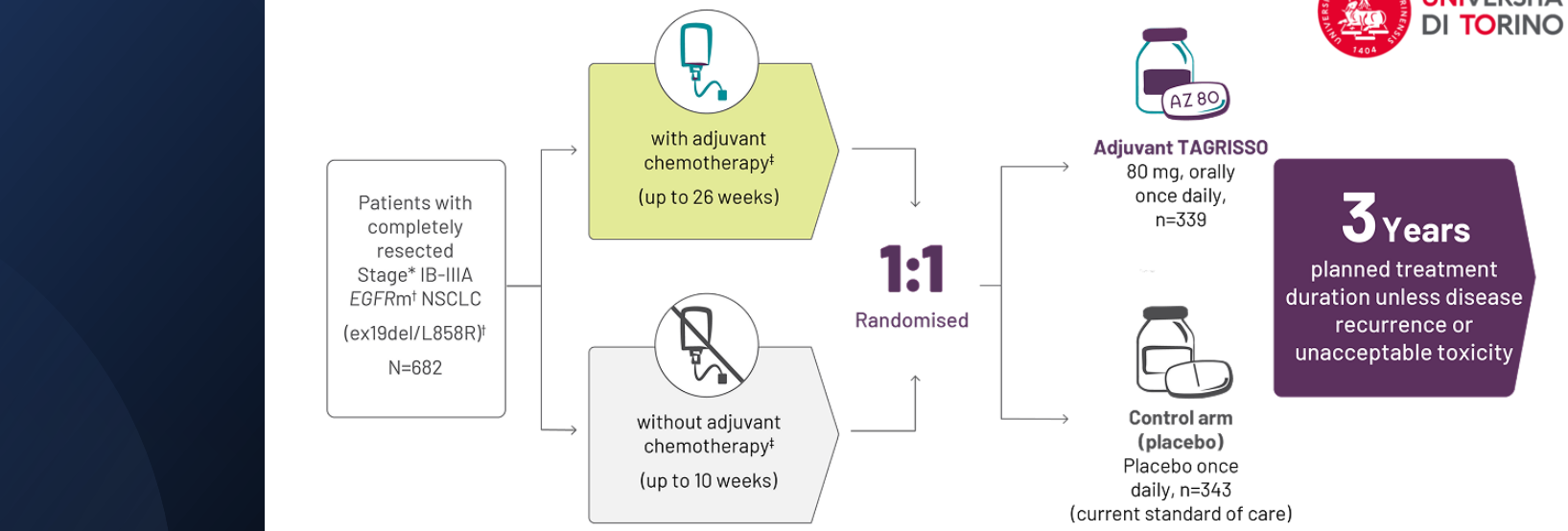
The **highest mediastinal node must be negative***

No extracapsular node involvement°

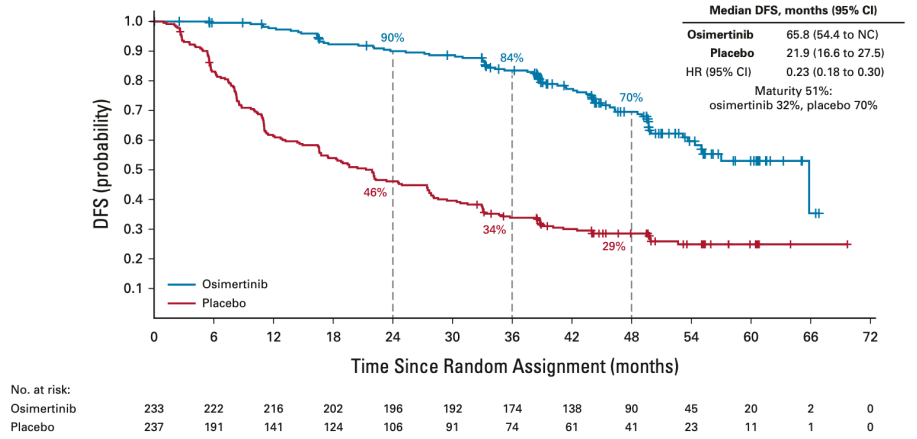
**R0(uncertain) if these criteria are not met*
°R1 if this criterion are not met

If resectable…

PARECHYNA SPARING RO PAIRS PERFECTLY WITH ADJUVANT OSIMERTINIB



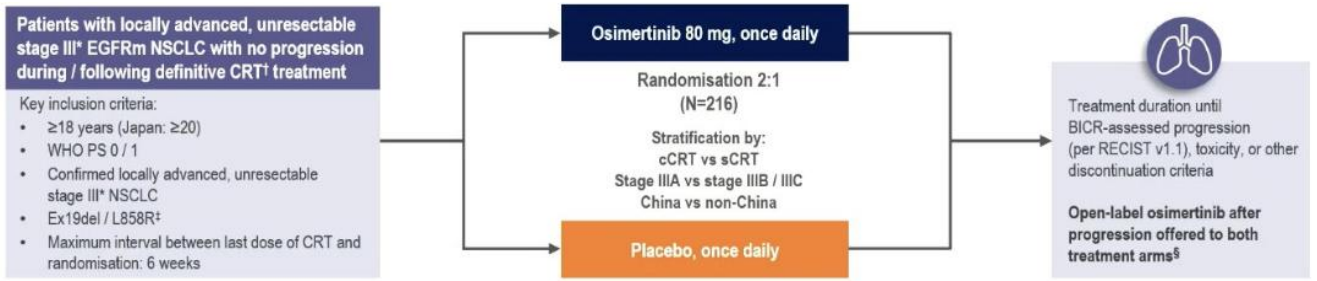
- **ADAURA:** 5-yr OS 85% (**DFS 2y 90%, mDFS 65.8 m)**
- **Surgery + adjuvant osimertinib** is a new **standard**



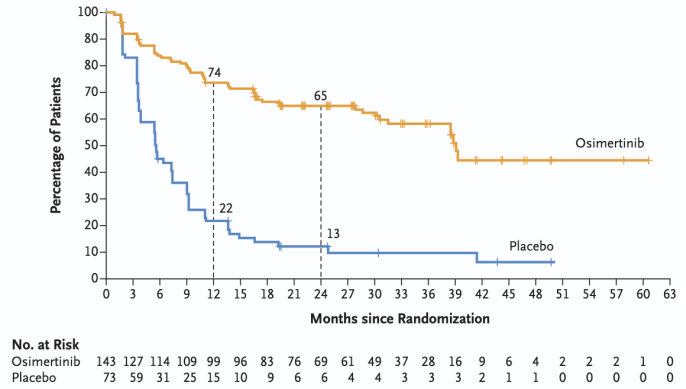
HR 0.23

If UNresectable…

WHAT LAURA REALLY TELLS US … AND WHAT IT DOESN'T



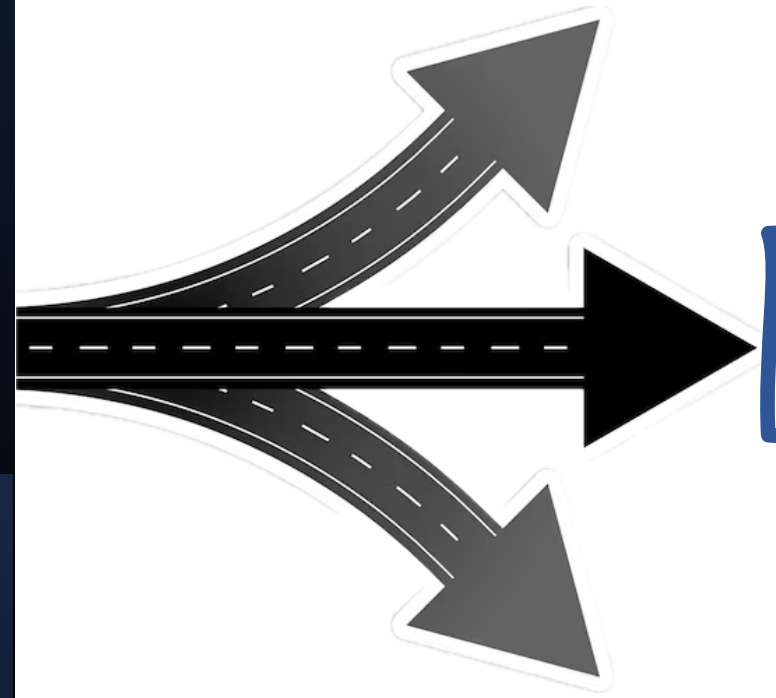
- **Unresectable stage III after concurrent CRT:** osimertinib massively prolongs outcomes. (**PFS 2y 65%, mPFS 39.1 m**)
- Thus, if **truly unresectable**, CRT+osimertinib is the **standard**.
- **Not a substitute** for resection when **R0** is feasible.



HR 0.16

The crossroads

Non-pneumonectomy (lobectomy/sleeve/bilobectomy feasible)



Achieve **complete macroscopic clearance** + targeted **adjuvant therapy**

Right pneumonectomy needed (fit pt., R0 achievable)

GO TO SURGERY

RO resection!



"Whatever it takes."

Living with one lung

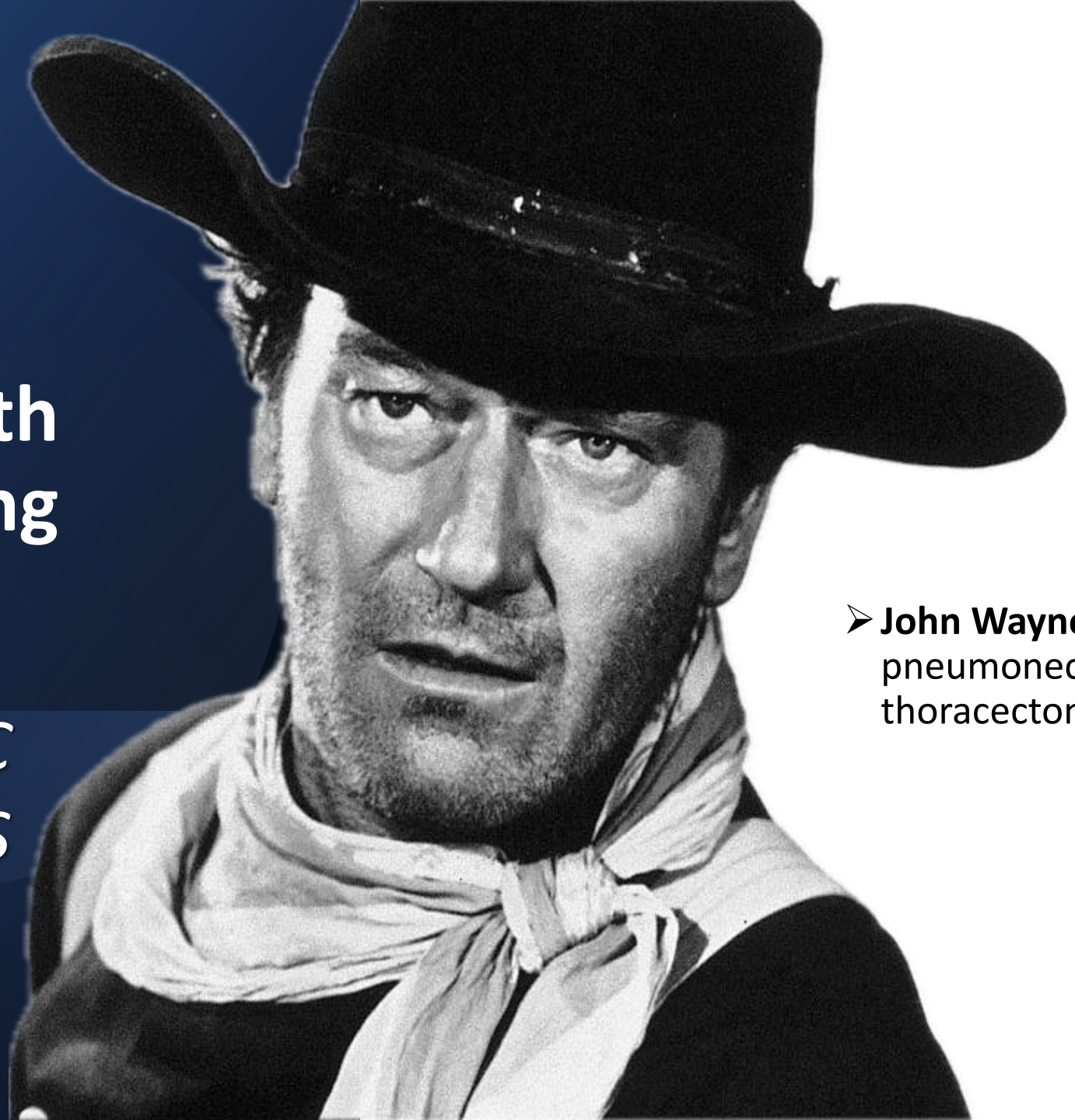
PUBLIC EXAMPLES



- **King George VI:** left pneumonectomy due to lung cancer

Living with one lung

PUBLIC EXAMPLES



- **John Wayne:** left pneumonectomy and two ribs thoracectomy

Living with one lung

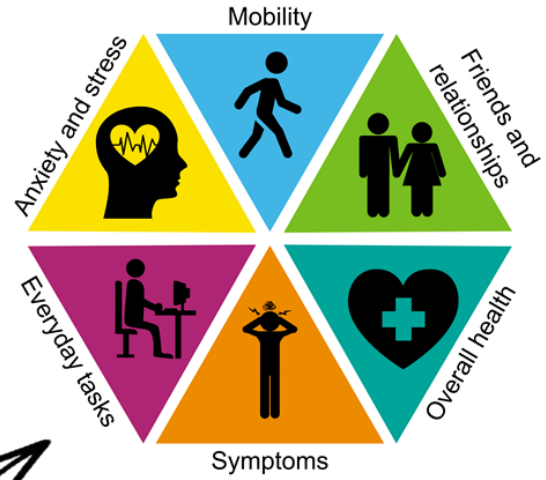
PUBLIC EXAMPLES



- **Nat “King” Cole:** left pneumonectomy

The crossroads

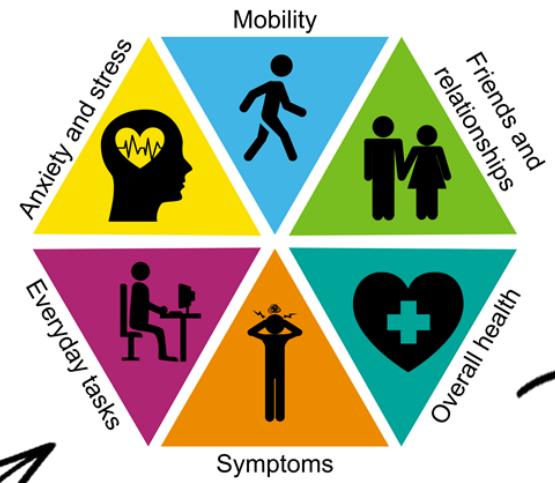
CONSIDER PATIENT RESIDUAL QUALITY OF LIFE



SURGERY ??

Right pneumonectomy needed (fit pt., R0 achievable)

The crossroads
NOT SURGERY ALONE



➢ Achieve complete macroscopic clearance + ??? **targeted adjuvant therapy** ???

SURGERY ??

Right pneumonectomy needed (fit pt., R0 achievable)

Right Pneumonectomy

PERIOPERATIVE AND EARLY ISSUES

1

Higher **early mortality** vs. left, especially after induction therapy: 30-day **8.2%** vs 4.2%; 90-day **13.6%** vs 6.4% (right vs left) in a large national analysis**.**

2

Bronchopleural fistula (BPF) drives much of the excess risk on the right; classic series show higher BPF incidence after right pneumonectomy and link it to mortality.

3

BPF risk factors to consider: pre-op radiation dose, low albumin, stump technique/length; risk-model approaches exist to estimate BPF risk.

4

Post-pneumO pulmonary edema (PPPE): uncommon but life-threatening; associated with right side and liberal fluids → favor restrictive fluid strategy and close ICU monitoring.

5

Other early complications to proactively prevent/manage: **AFib, pneumonia, PE**



Right Pneumonectomy

LATE AND LONG-TERM ISSUES

1

Post-pneumonectomy syndrome (PPS): dynamic airway compression from mediastinal shift; majority of adult PPS cases follow right pneumonectomy; treat with mediastinal repositioning/expanders.

2

Long-term outcomes: despite higher early risk, long-term mortality is **not worse** for right vs left when patients survive the peri-operative window (national cohort).

3

Function & QoL: many patients achieve **acceptable** function with structured pulmonary rehabilitation; tailor surveillance and rehab to comorbidity profile.

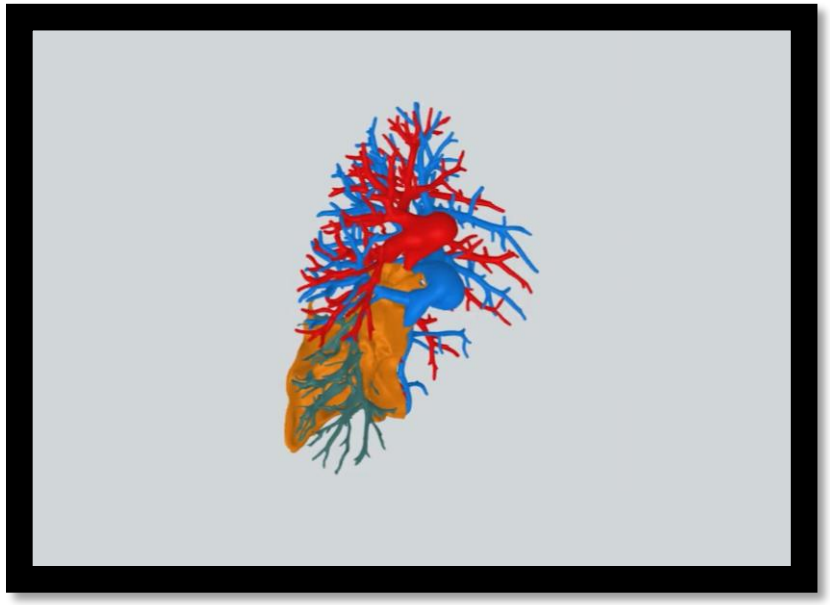
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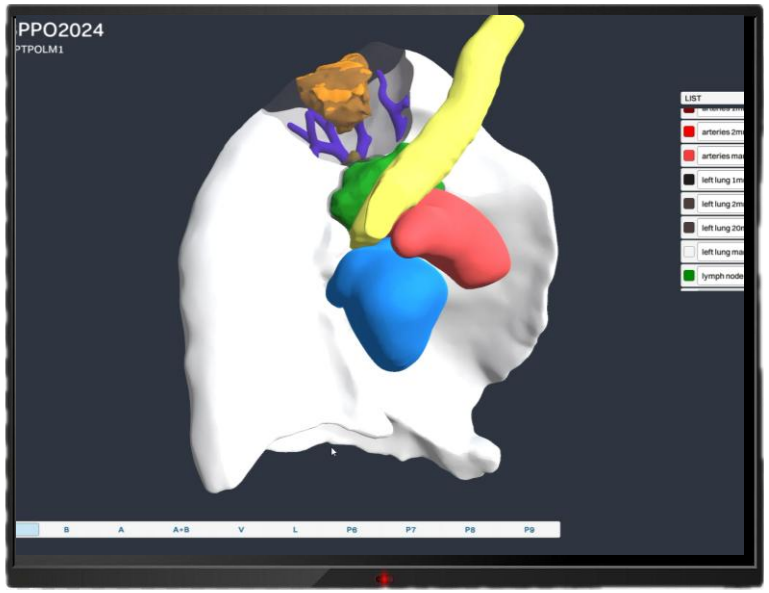
Follow-up priorities: watch for **airway symptoms** (PPS), **late BPF**, optimize cardiovascular risk, and adapt CNS surveillance to tumor biology (e.g., EGFR).

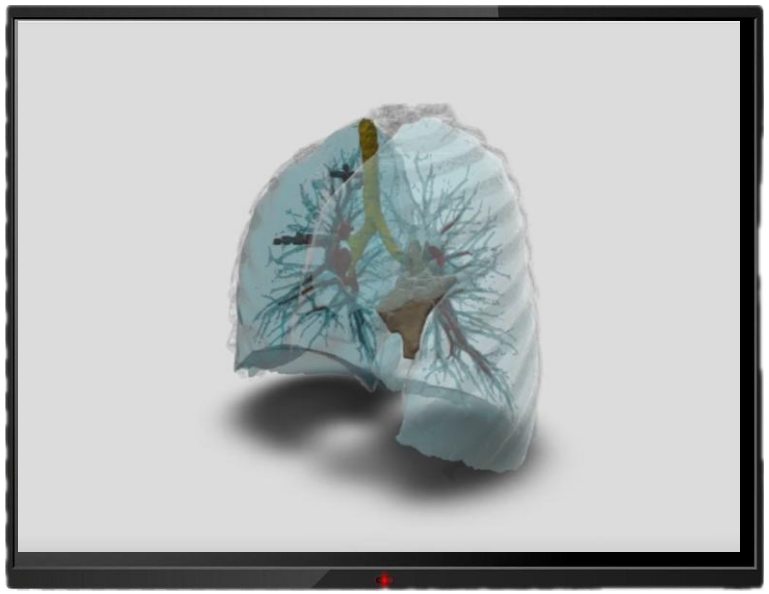


Studying Pneumonectomy

3D RECONSTRUCTIONS

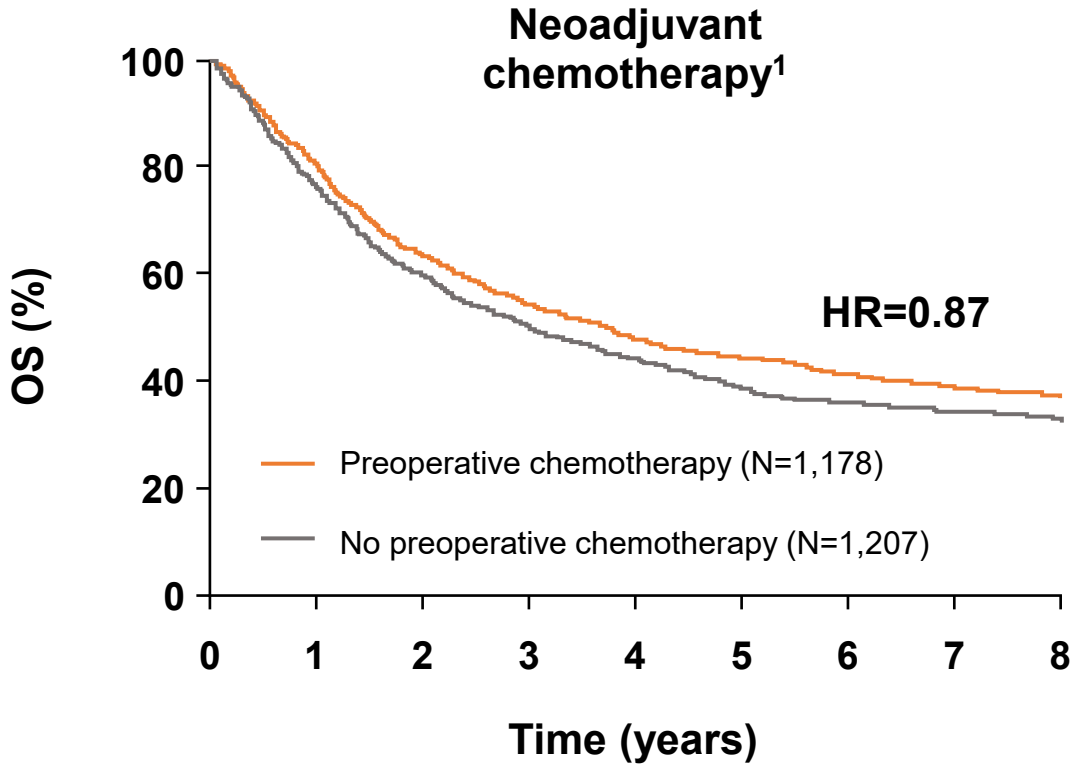






Avoiding Pneumonectomy

Neoadiuvant theraopy

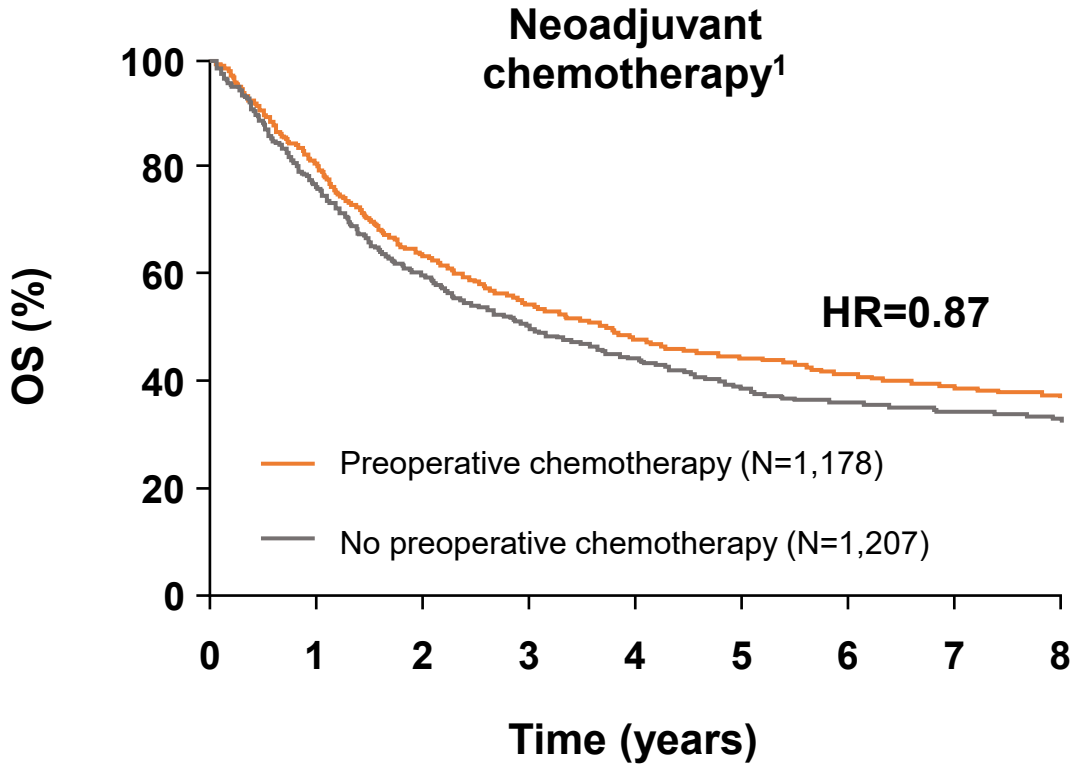


5%

improvement in 5-year OS

Avoiding Pneumonectomy

Neoadiuvant theraopy



Borderline case

Technically resectable, but where surgery carries a **higher risk of incomplete resection** (R1/R2), **higher perioperative morbidity**, or **uncertain oncologic benefit** due to **tumor** extent, **nodal** involvement, or **patient**-related factors.

Take home

If **R0** resection is technically achievable and **the patient is fit → Go to Surgery** (??? even if right pneumonectomy may be required ???)**.**

Pair surgery with adjuvant osimertinib (ADAURA). NOT SURGERY ALONE



CRT+osimertinib (LAURA) for unresectable cases.. And not multimodal cases.

Multidisciplinary selection + center experience mitigate peri-op risk; long-term outcomes justify the approach.

Take Home

ALWAYS** TAKE INTO ACCOUNT **QUALITY OF LIFE, EARLY** AND **LONG-TERM OUTCOMES

PATIENT OPINION MATTERS





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