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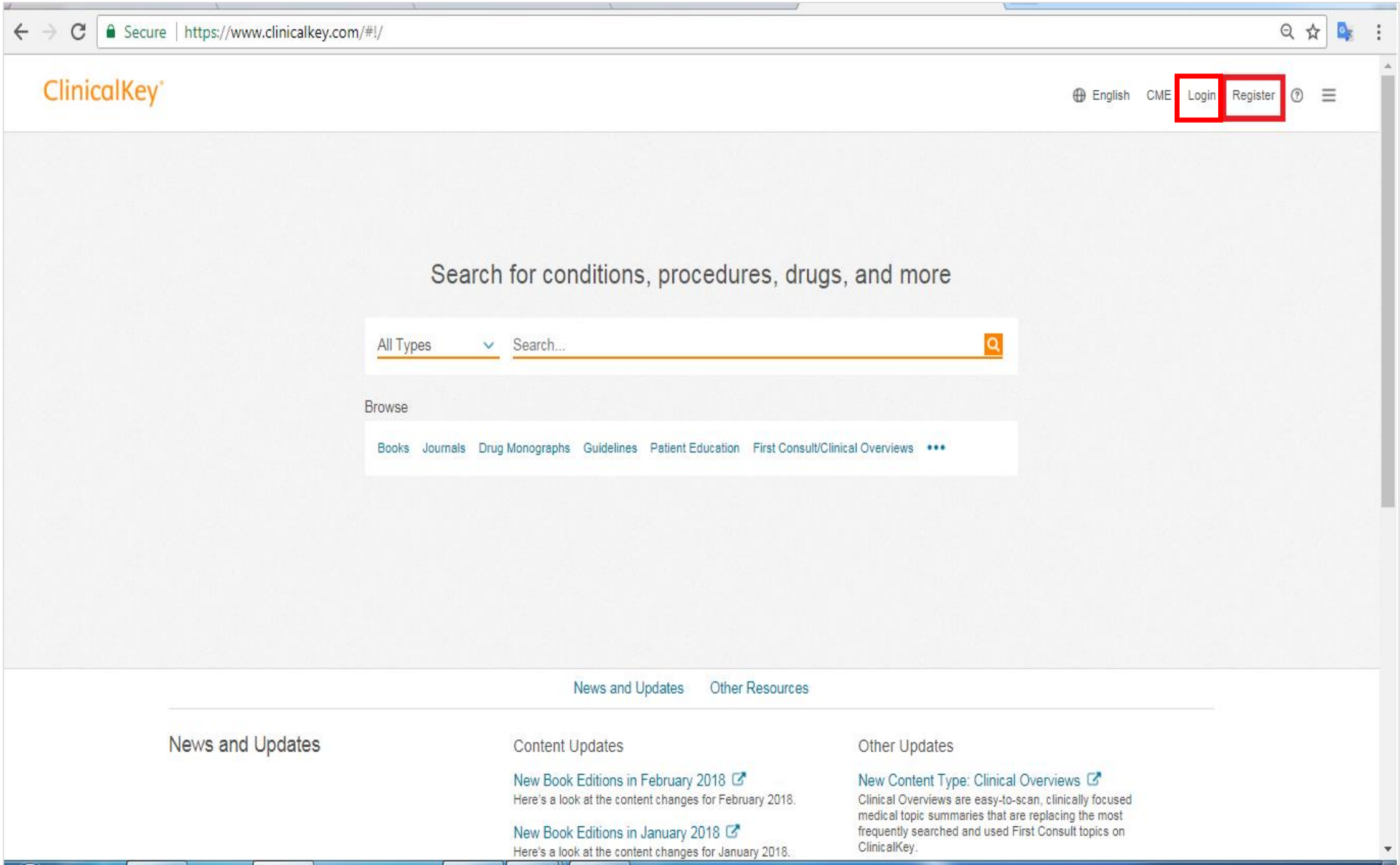
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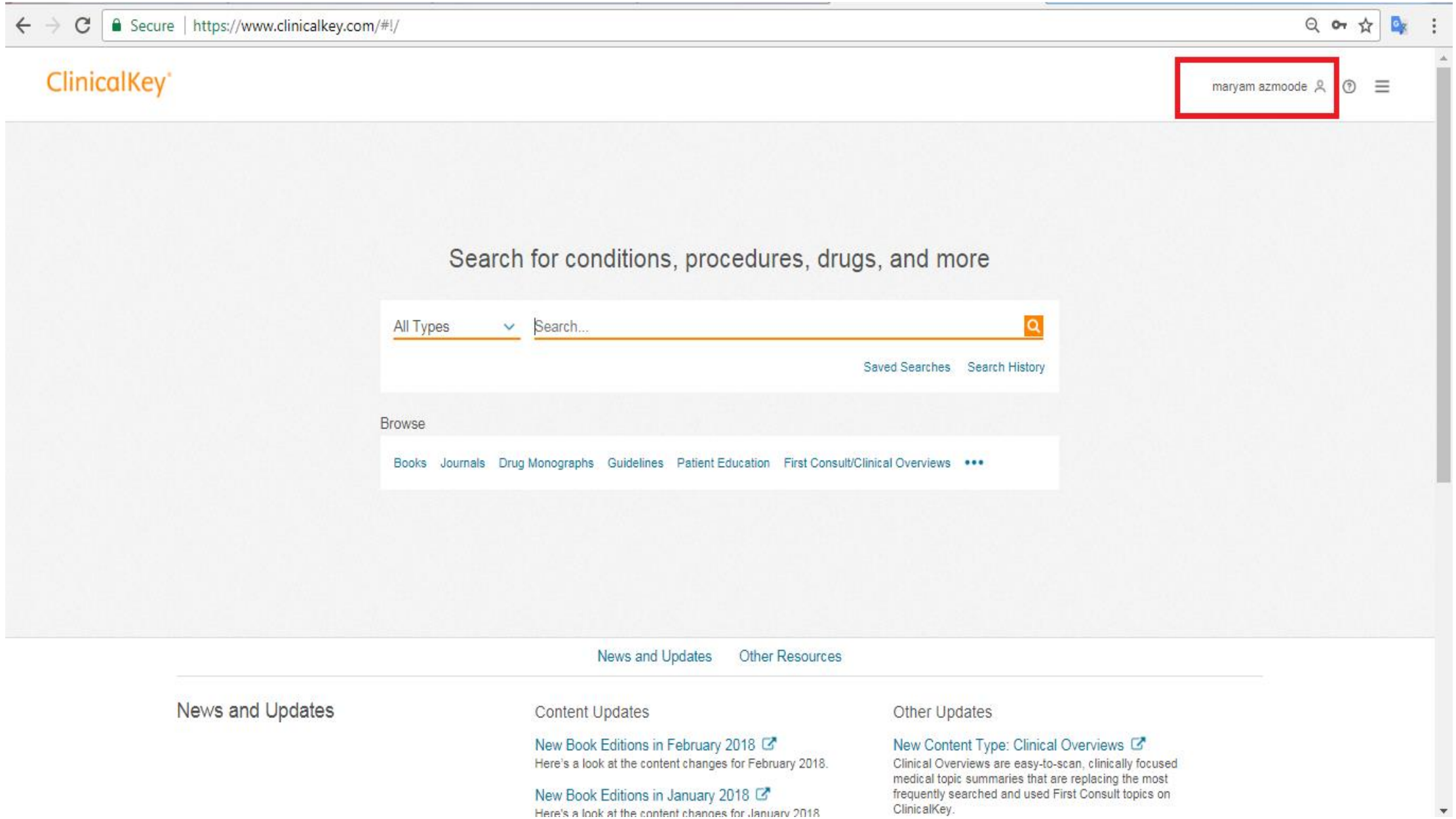
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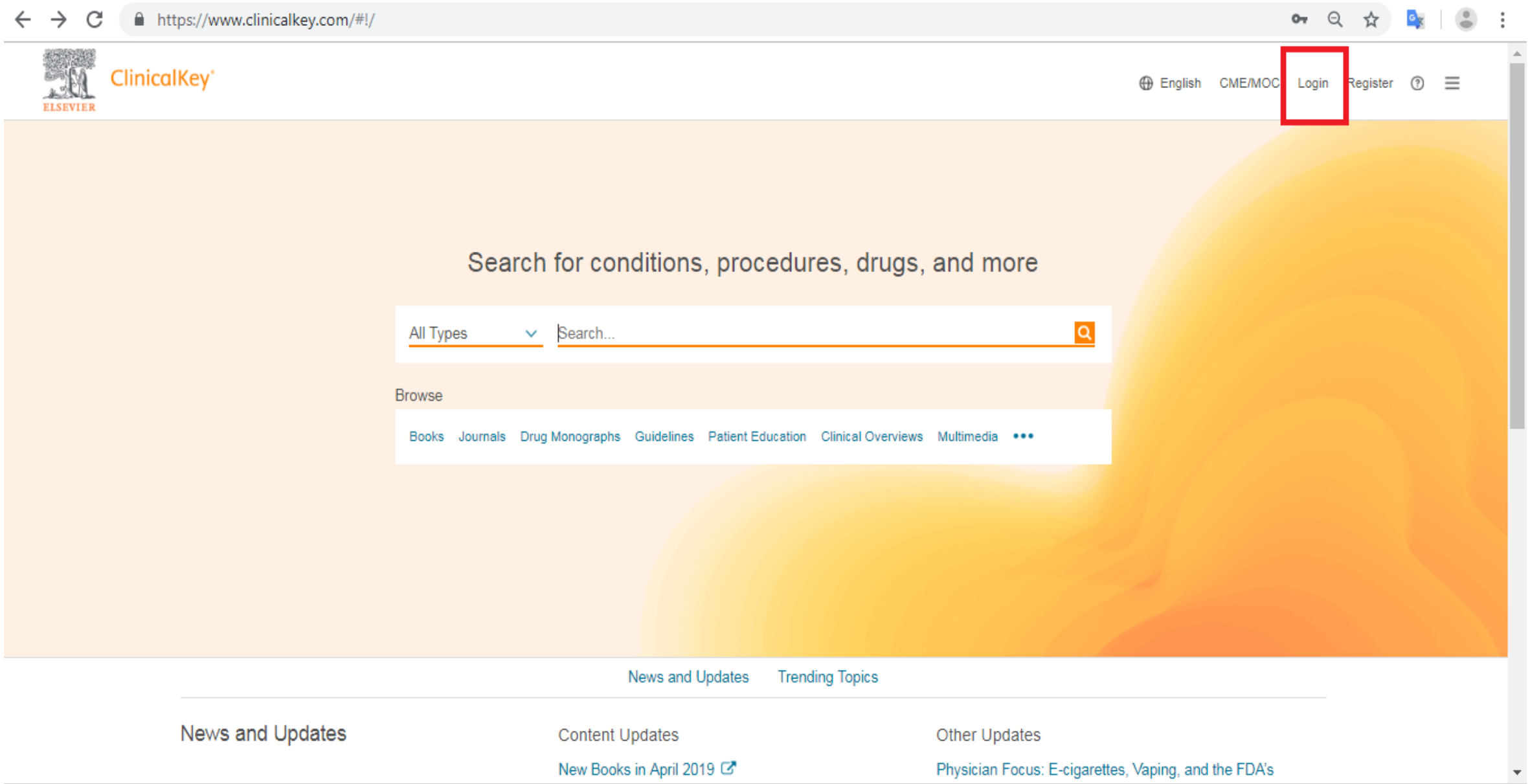
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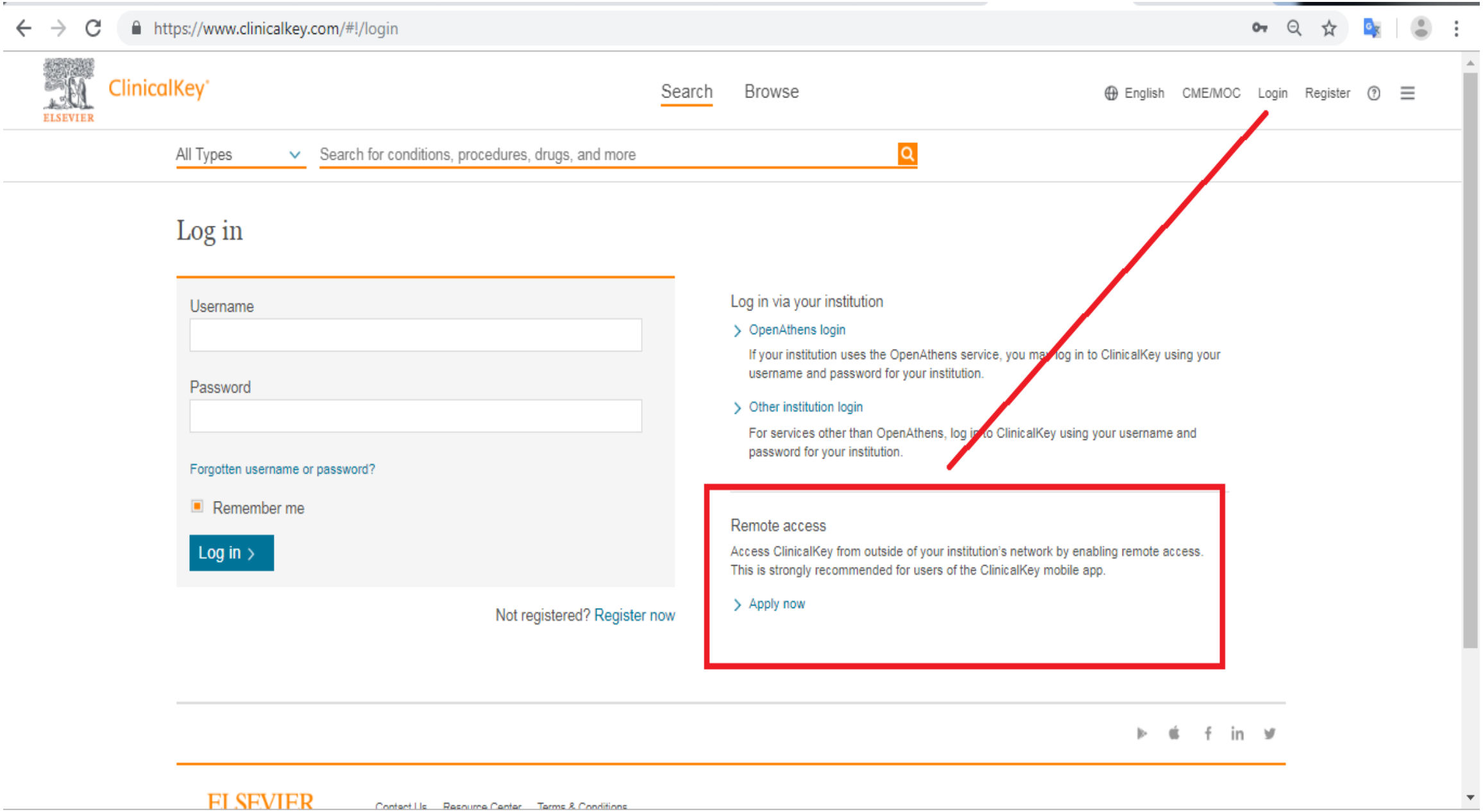
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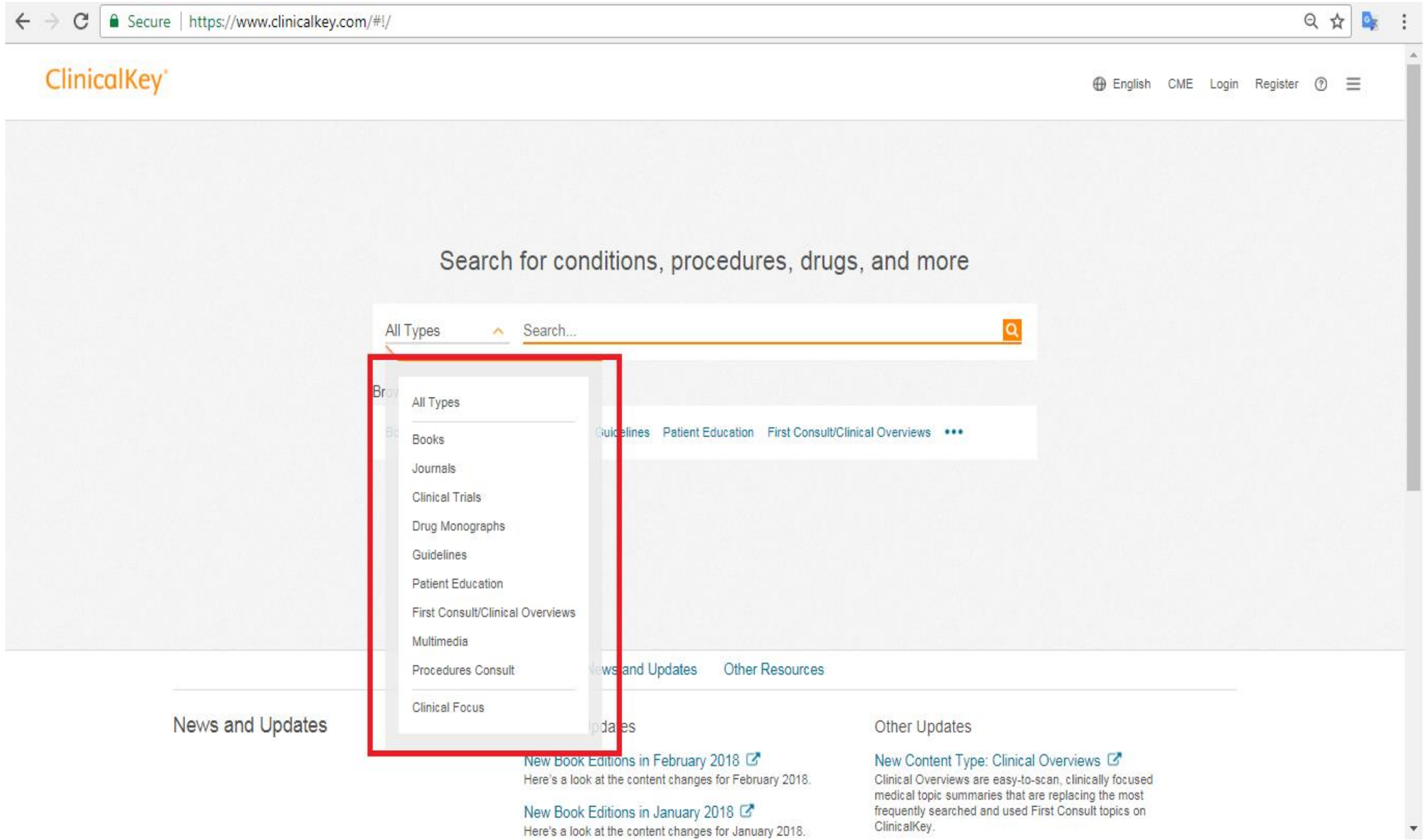
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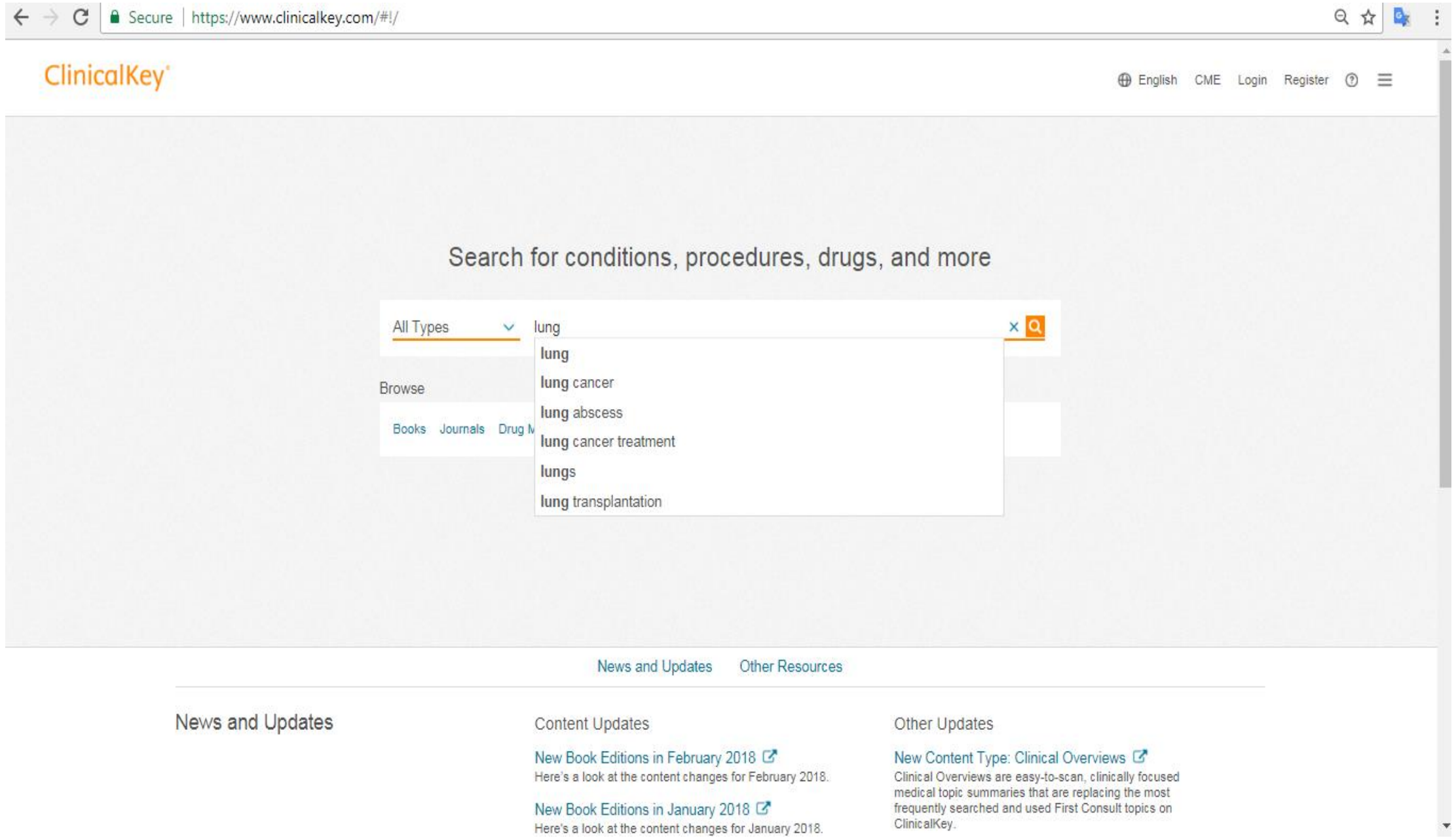
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Key Points

Non–small cell lung cancer comprises approximately 80% to 85% of all new lung cancer diagnoses. The most common histologies are adenocarcinoma and squamous cell carcinoma; a small percentage are undifferentiated large cell carcinomas

Tobacco smoking is the most important risk factor, and smokers with a 30 pack-year smoking history are screened annually with low-dose CT

Initial symptoms may be related to a primary tumor (eg, cough, dyspnea, hemoptysis), metastatic disease (eg, bone pain, central nervous system symptoms), overall tumor burden (eg, weight loss), or less commonly, a paraneoplastic syndrome (eg, hypercalcemia, hyponatremia with syndrome of inappropriate antidiuretic hormone production, ectopic ACTH production)

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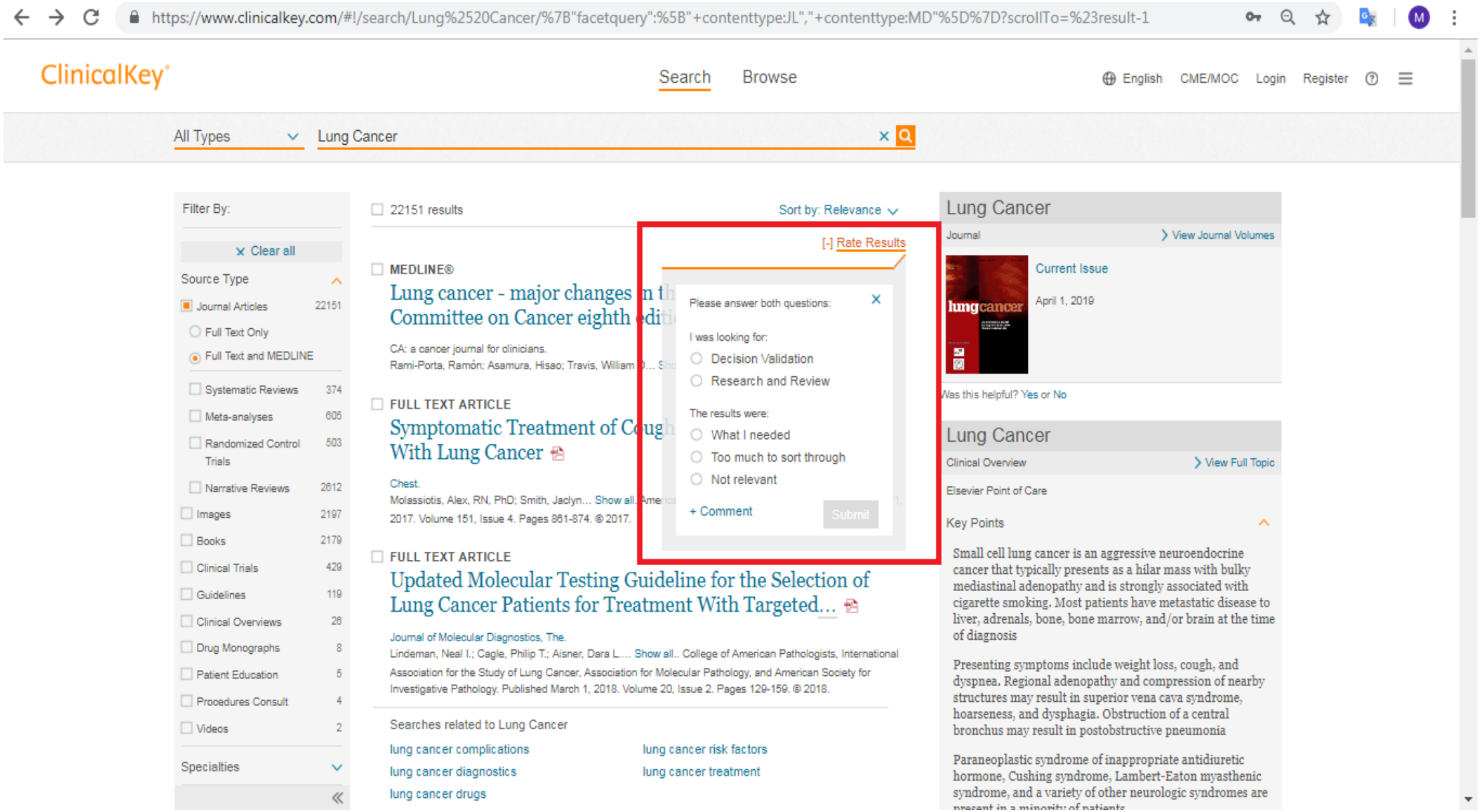
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Key Points
Small cell lung cancer is an aggressive neuroendocrine cancer that typically presents as a hilar mass with bulky mediastinal adenopathy and is strongly associated with cigarette smoking. Most patients have metastatic disease to liver, adrenals, bone, bone marrow, and/or brain at the time of diagnosis
Presenting symptoms include weight loss, cough, and dyspnea. Regional adenopathy and compression of nearby structures may result in superior vena cava syndrome, hoarseness, and dysphagia. Obstruction of a central bronchus may result in postobstructive pneumonia
Paraneoplastic syndrome of inappropriate antidiuretic hormone, Cushing syndrome, Lambert-Eaton myasthenic syndrome, and a variety of other neurologic syndromes are

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CME

Panel Composition

Conflict of Interest Policy

Objective

Methods

Systematic Literature Review and Analysis

Eligible Study Designs

Inclusion Criteria

Quality Assessment

Assessing the Strength of Recommendations

Guideline Revision

Disclaimer

Results

Guideline Statements

Reaffirmation of 2013 Recommendations

New Recommendations

FULL TEXT ARTICLE

Updated Molecular Testing Guideline for the Selection of Lung Cancer Patients for Treatment With Targeted Tyrosine Kinase Inhibitors

Neal I. Lindeman, Philip T. Cagle, Dara L. Aisner, Maria E. Arcila, Mary Beth Beasley, Eric H. Bernicker, Carol Colasacco, Sanja Dacic, Fred R. Hirsch, Keith Kerr, David J. Kwiatkowski, Marc Ladanyi, Jan A. Nowak, Lynette Sholl, Robyn Temple-Smolkin, Benjamin Solomon, Lesley H. Souter, Erik Thunnissen, Ming S. Tsao, Christina B. Ventura, Murry W. Wynes and Yasushi Yatabe

Journal of Molecular Diagnostics, The, 2018-03-01, Volume 20, Issue 2, Pages 129-159, Copyright © 2018 College of American Pathologists, International Association for the Study of Lung Cancer, Association for Molecular Pathology, and American Society for Investigative Pathology

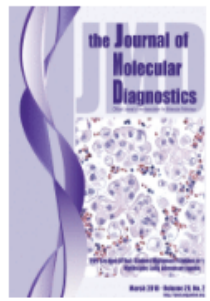
Context

In 2013, an evidence-based guideline was published by the College of American Pathologists, the International Association for the Study of Lung Cancer, and the Association for Molecular Pathology to set standards for the molecular analysis of lung cancers to guide treatment decisions with targeted inhibitors. New evidence has prompted an evaluation of additional laboratory technologies, targetable genes, patient populations, and tumor types for testing.

Objective

To systematically review and update the 2013 guideline to affirm its validity; to assess the evidence of new genetic discoveries, technologies, and therapies; and to issue an evidence-based update.

Design



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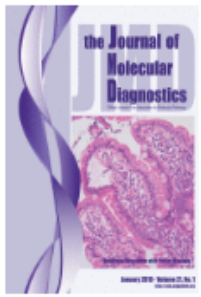

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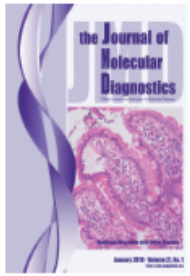

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Lung Cancer and Other Pulmonary Neoplasms

Fadlo R. Khuri

Goldman-Cecil Medicine, 191, 1303-1313.e3

Bronchogenic Lung Cancer

Definition

Lung cancer, or bronchogenic carcinoma, is a proliferative malignant neoplasm arising from the primary respiratory epithelium. Lung cancer is generally divided into two major histologic groups: *non–small cell lung cancer* (NSCLC), which accounts for approximately 85% of all lung cancers, and *small cell lung cancer* (SCLC). There are several other less common pulmonary neoplasms including carcinoid tumors, primary soft tissue sarcomas of the lung, pulmonary blastomas, and lymphoma.

Epidemiology

Lung cancer is by far the leading cause of cancer-related mortality globally, with an estimated 1.3 million new cases diagnosed worldwide each year, accounting for nearly 12% of all cancers and an estimated 1.1 million deaths each year. Among men, lung cancer is the most common malignant neoplasm (incidence rate of 35.5 per 100,000), whereas in women, lung cancer incidence (12.1 per 100,000) is next only to breast, cervix, and colon cancers. The incidence and mortality related to lung cancer in men have declined during the last two decades in Western countries but continue to increase in the developing world; in women, lung cancer deaths are increasing in most regions of the world. The most dramatic increases in lung cancer incidence and death globally are in China, which has experienced a 465% increase in lung cancer–related deaths during the past 30 years.

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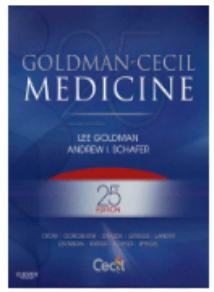

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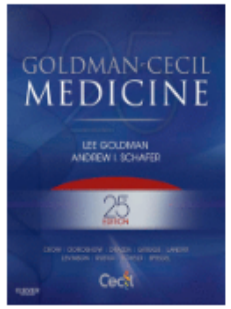

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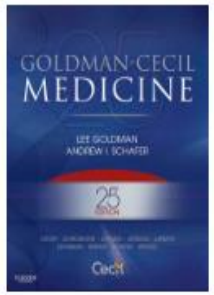

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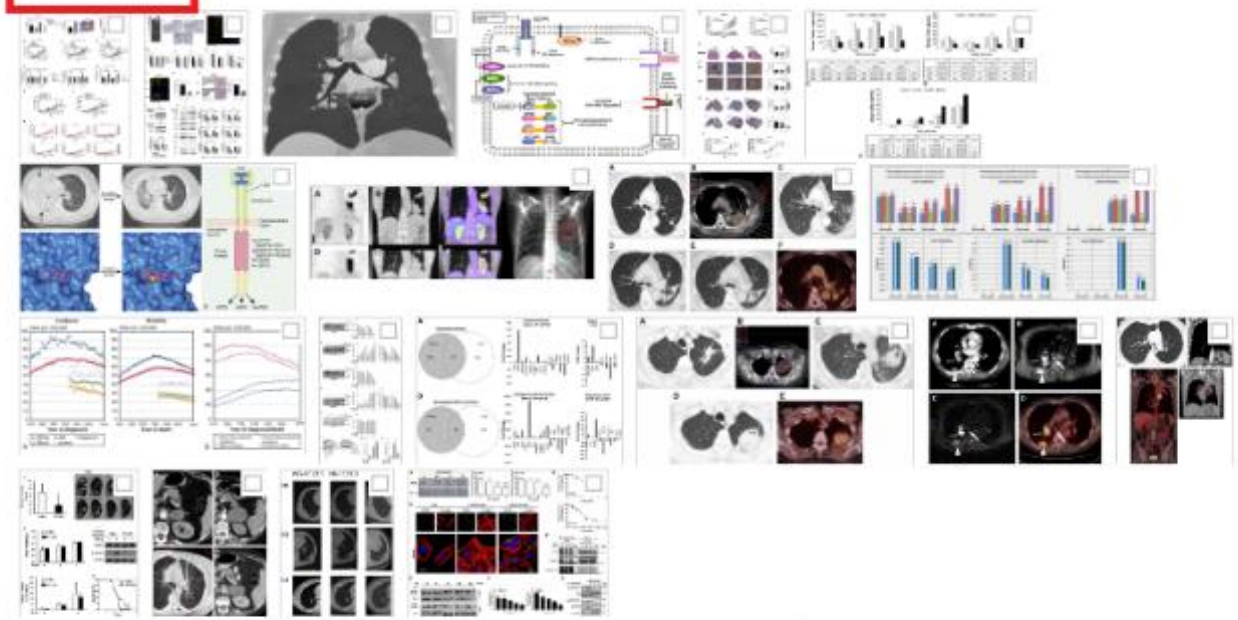

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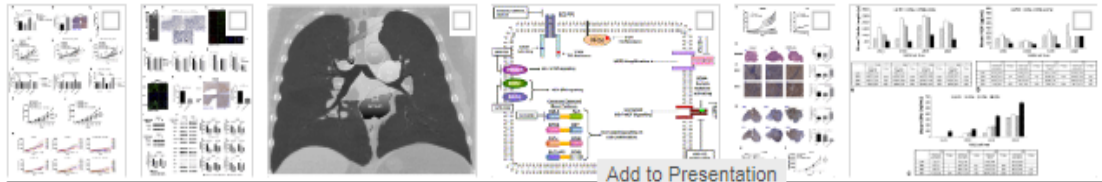

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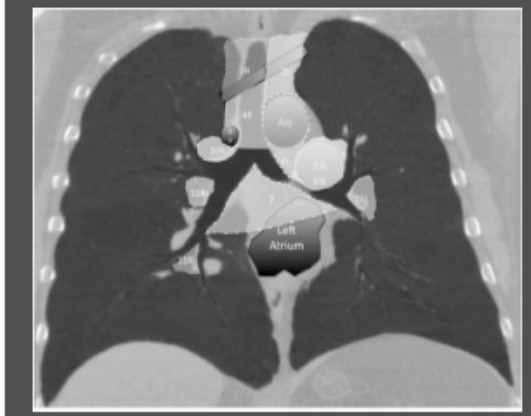

IMAGE

Diagnosing and Staging Lung Cancer Involving the Mediastinum

Chest.

Murgu, Septimiu Dan, MD, FCCP... Published May 1, 2015. Volume 147, Issue 5. Pages 1401-1412. © 2015.

Figure 3 Diagram illustrating the mediastinal, hilar, and interlobar lymph node stations relevant for staging and accessible by endobronchial ultrasound transbronchial needle aspiration (stations 2, 4, 7, 10, and 11). The upper and lower borders are based on the revised International Association for the Study of Lung Cancer lymph node map. Station 2R includes nodes extending to the left lateral border of the trachea. The upper border is the apex of the right lung and pleural space and, in the midline, the upper border of the manubrium, and the lower border is the intersection of caudal margin of innominate vein with the trachea. Station 2L includes nodes extending to the left of the left lateral border of the trachea. The upper border is the apex of the left lung and pleural space and, in the midline, the upper border of the manubrium, and the lower border is the superior border of the aortic arch. Station 4R includes right lower paratracheal nodes and pretracheal nodes extending to the left lateral border of trachea. The upper border is the intersection of caudal margin of innominate vein with the trachea, and the lower border is the lower border of azygos vein. Station 7 is the subcarinal nodal station with the upper border composed of the carina of the trachea and the lower border composed of the upper border of the lower lobe bronchus on the left and the lower border of the bronchus intermedius on the right. Station 4L includes nodes to the left of the left lateral border of the trachea, medial to the ligamentum arteriosum. The upper border is the upper margin of the aortic arch, and the lower border is the upper rim of the left main pulmonary artery. Station 10R includes nodes immediately adjacent to the right mainstem bronchus and hilar vessels, including the proximal portions of the pulmonary veins and main pulmonary artery. The upper border is the lower rim of the azygos vein, and the lower border is the interlobar region between the right upper lobe and bronchus intermedius. Station 10L includes nodes immediately adjacent to the left mainstem bronchus and hilar vessels, including the proximal portions of the pulmonary veins and main pulmonary artery. The upper border is the upper rim of the left pulmonary artery, and the lower border is the interlobar region (left upper lobe and left lower lobe). Station 11R superior is composed of the nodes between the right upper lobe bronchus and bronchus intermedius. Station 11R inferior is between the middle and the right lower lobe bronchi. Station 11L is composed of the nodes between the origin of the left upper and lower lobar bronchi. Ao = aorta; PA = pulmonary artery.

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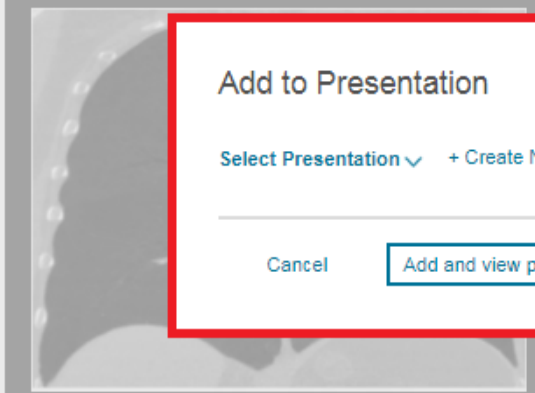

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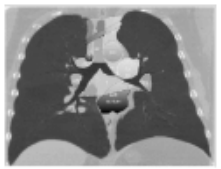

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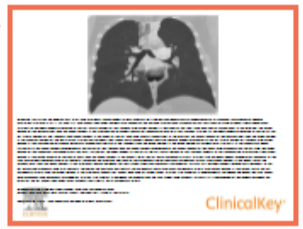

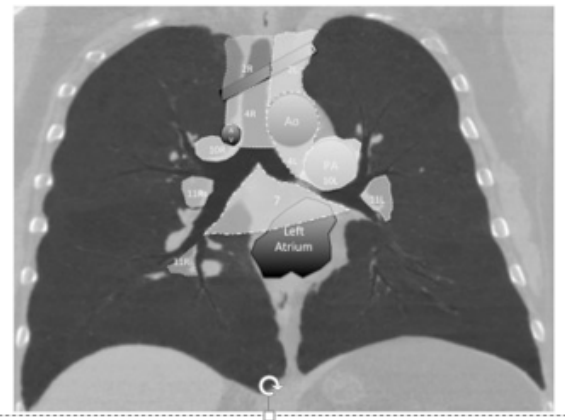

Diagram illustrating the mediastinal, hilar, and interlobar lymph node stations relevant for staging and accessible by endobronchial ultrasound transbronchial needle aspiration (stations 2, 4, 7, 10, and 11). The upper and lower borders are based on the revised International Association for the Study of Lung Cancer lymph node map. Station 2R includes nodes extending to the left lateral border of the trachea. The upper border is the apex of the right lung and pleural space and, in the midline, the upper border of the manubrium, and the lower border is the intersection of caudal margin of innominate vein with the trachea. Station 2L includes nodes extending to the left of the left lateral border of the trachea. The upper border is the apex of the left lung and pleural space and, in the midline, the upper border of the manubrium, and the lower border is the superior border of the aortic arch. Station 4R includes right lower paratracheal nodes and pretracheal nodes extending to the left lateral border of trachea. The upper border is the intersection of caudal margin of innominate vein with the trachea, and the lower border is the lower border of azygos vein. Station 7 is the subcarinal nodal station with the upper border composed of the carina of the trachea and the lower border composed of the upper border of the lower lobe bronchus on the left and the lower border of the bronchus intermedius on the right. Station 4L includes nodes to the left of the left lateral border of the trachea, medial to the ligamentum arteriosum. The upper border is the upper margin of the aortic arch, and the lower border is the upper rim of the left main pulmonary artery. Station 10R includes nodes immediately adjacent to the right mainstem bronchus and hilar vessels, including the proximal portions of the pulmonary veins and main pulmonary artery. The upper border is the lower rim of the azygos vein, and the lower border is the interlobar region between the right upper lobe and bronchus intermedius. Station 10L includes nodes immediately adjacent to the left mainstem bronchus and hilar vessels, including the proximal portions of the pulmonary veins and main pulmonary artery. The upper border is the upper rim of the left pulmonary artery, and the lower border is the interlobar region (left upper lobe and left lower lobe). Station 11R superior is composed of the nodes between the right upper lobe bronchus and bronchus intermedius. Station 11R inferior is between the middle and the right lower lobe bronchi. Station 11L is composed of the nodes between the origin of the left upper and lower lobar bronchi. Ao = aorta; PA = pulmonary artery.

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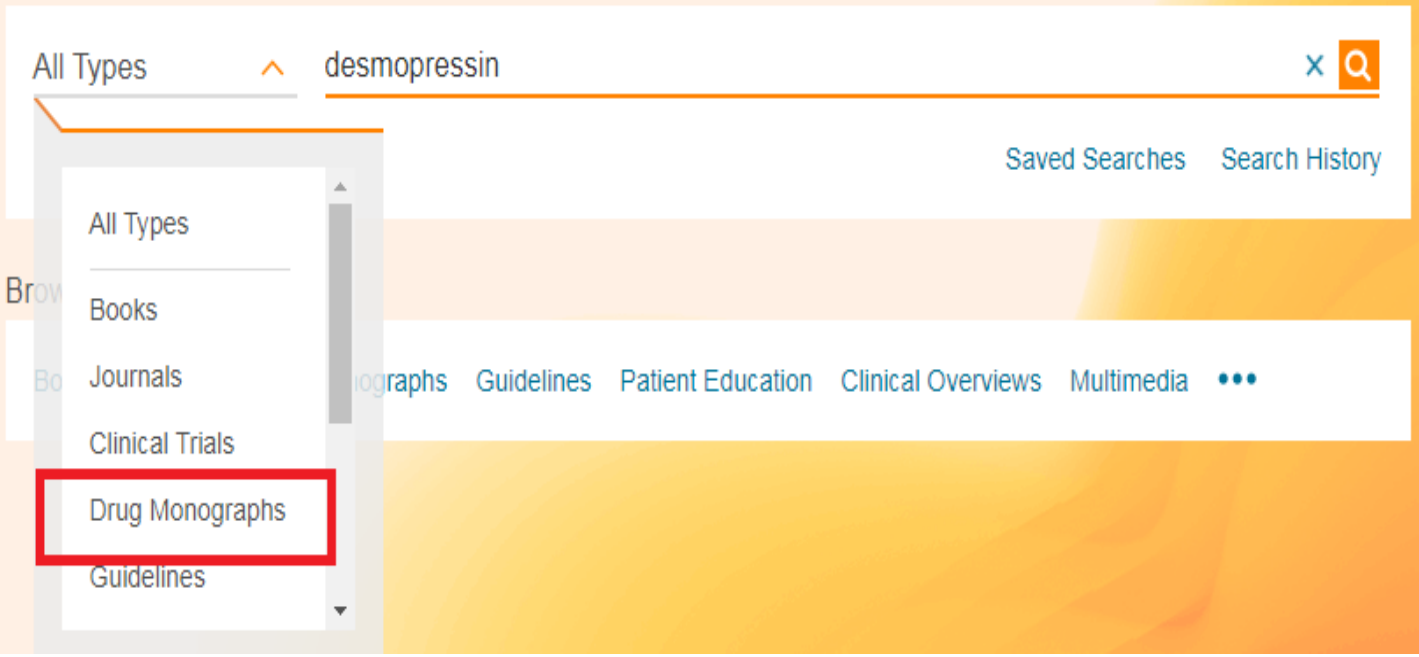

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Indications & Dosage
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Desmopressin

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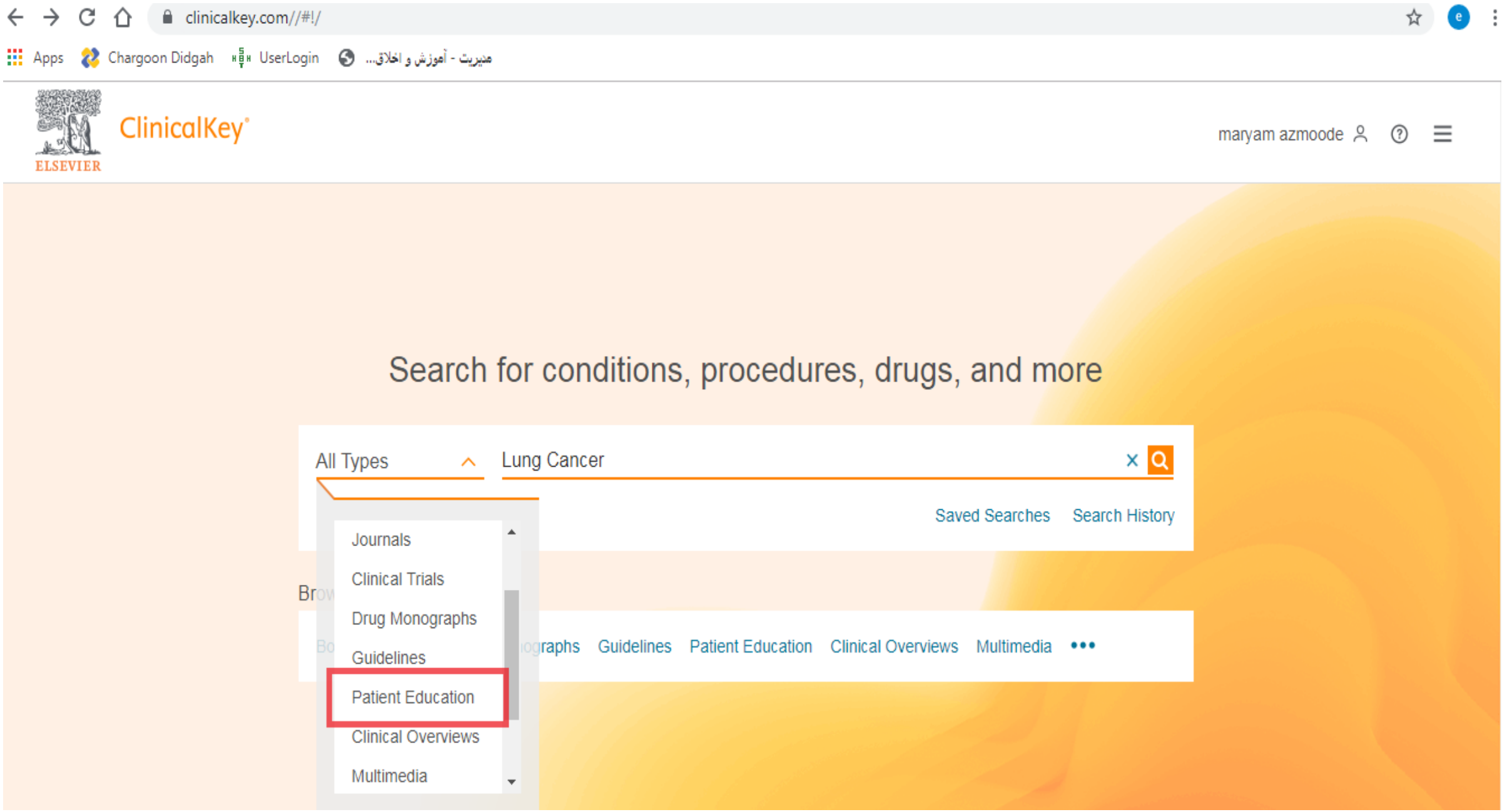
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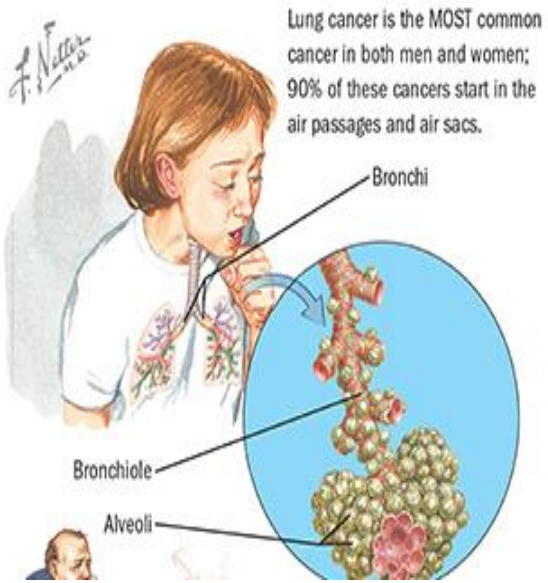

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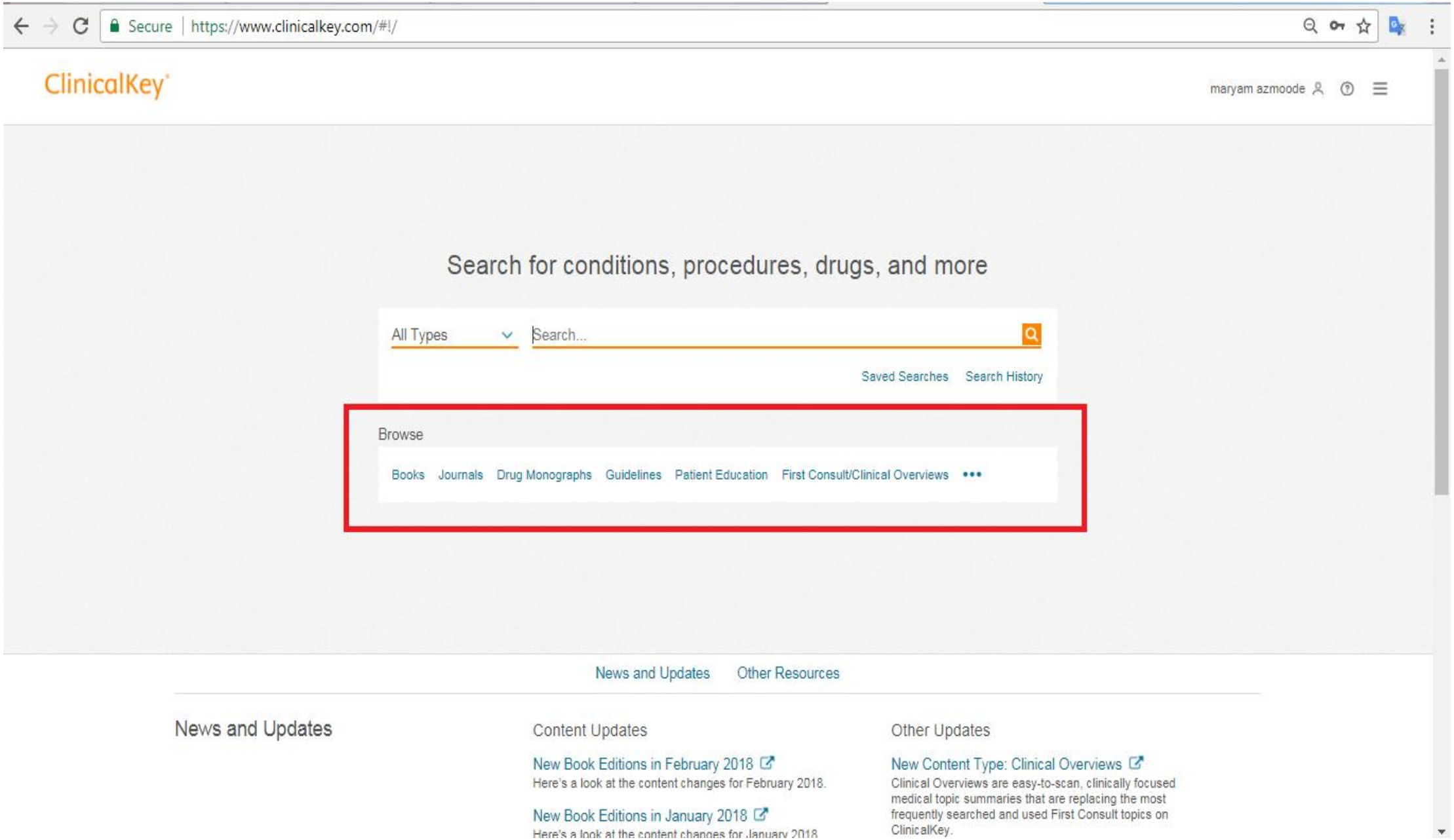
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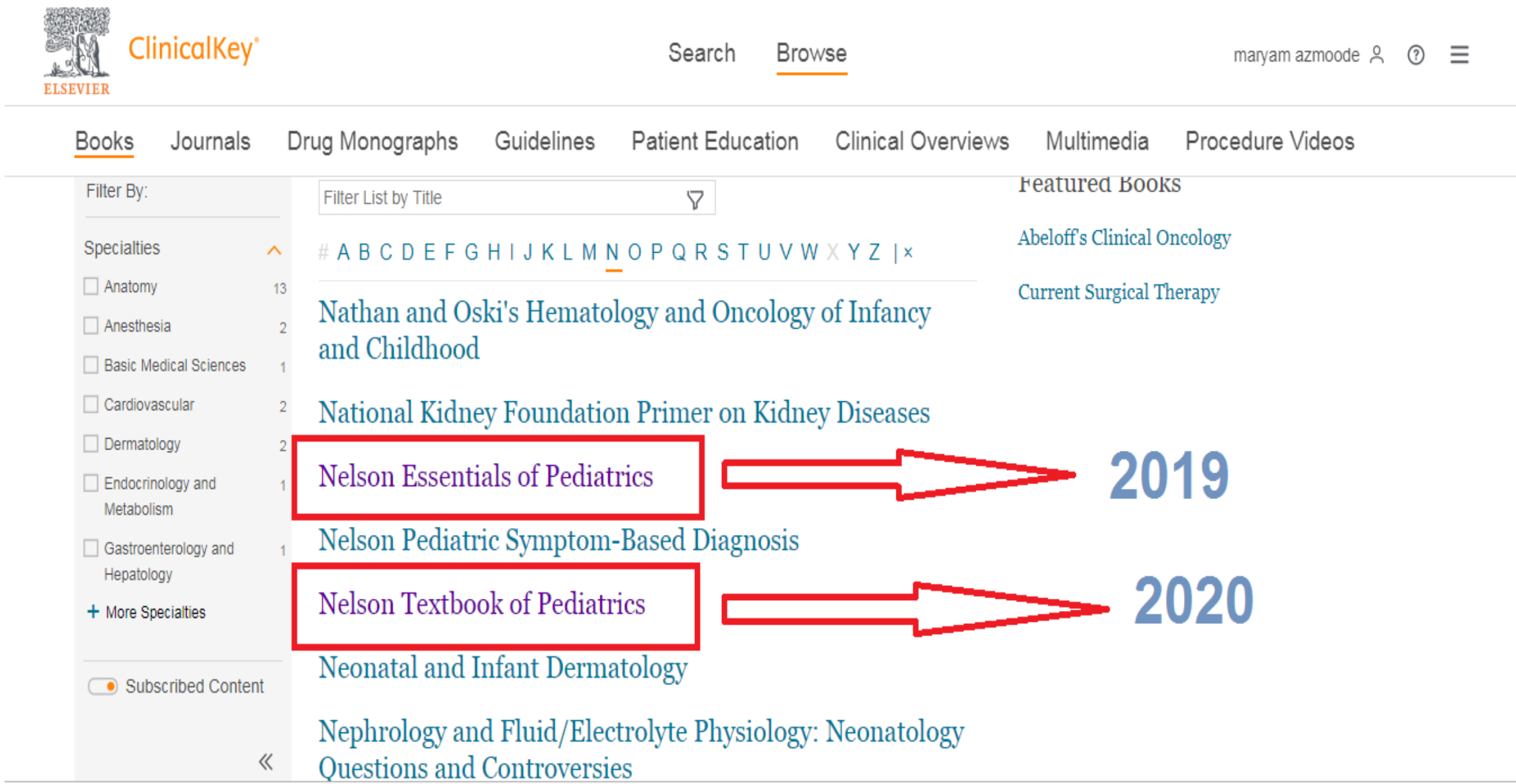
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Lee A. Fleisher.. Published September 21, 2016.

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Lee A. Fleisher.. Published September 16, 2016.

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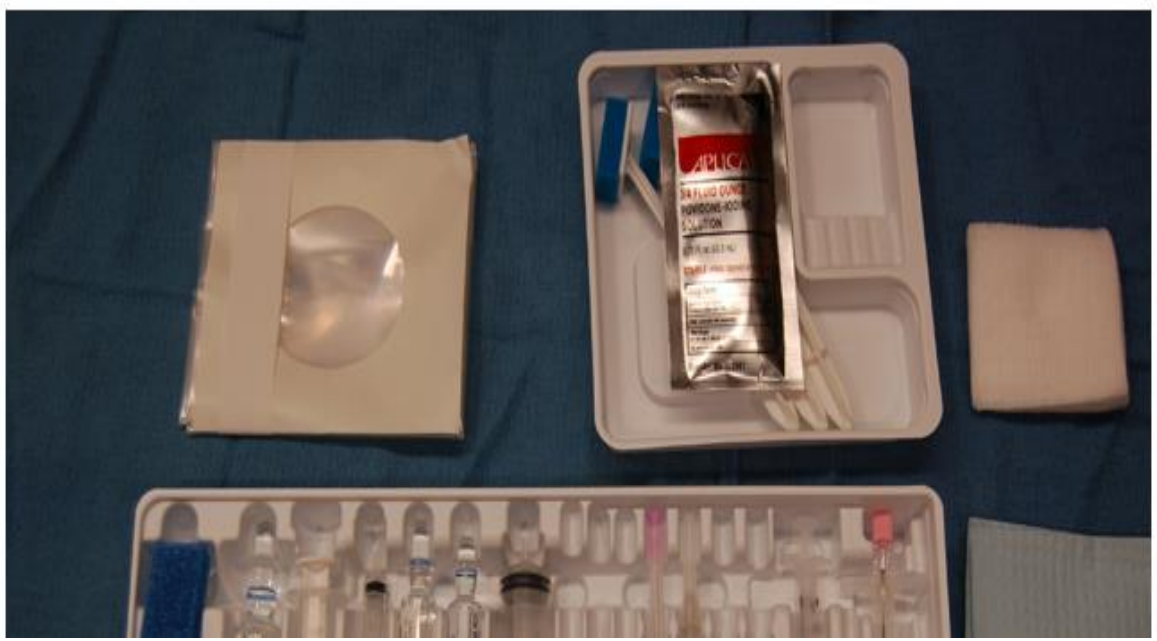
Lee A. Fleisher.. Published September 25, 2016.

CONTRAINDICATIONS

Presence of neurological disease such as multiple sclerosis or infectious disease such as HIV without central nervous system involvement are often cited as a absolute contraindications to epidural analgesia, but the prevailing evidence is that thoracic epidural analgesia can be safely delivered in such circumstances.[1]

EQUIPMENT

(See Figure 1).



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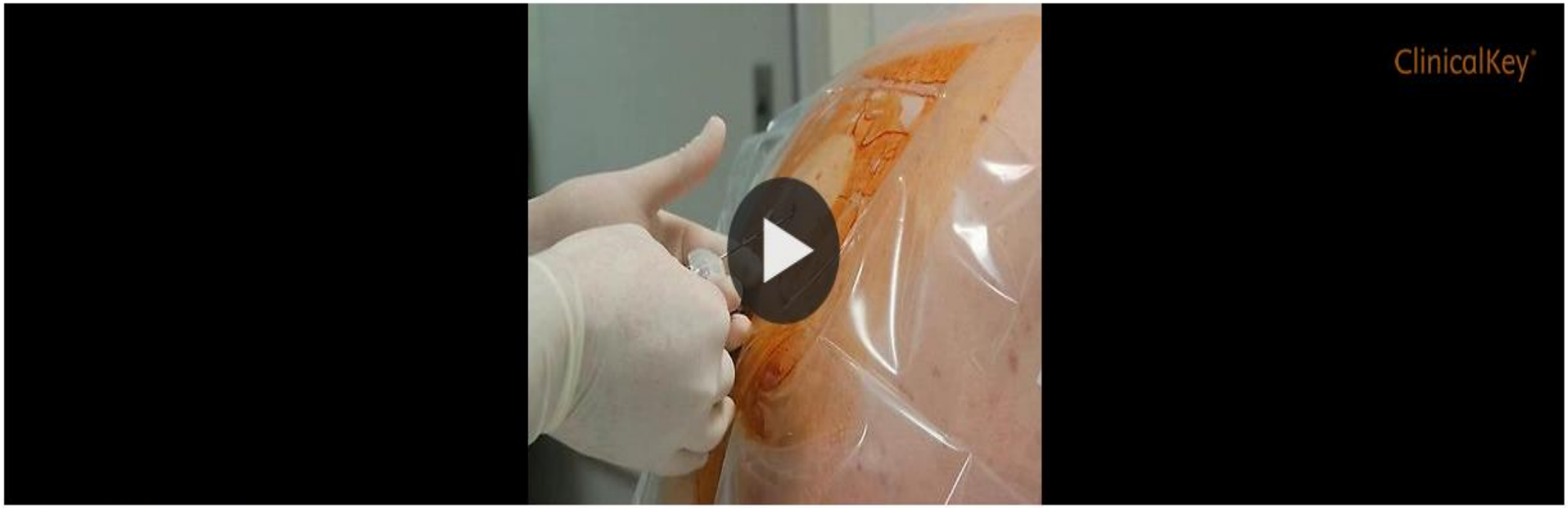

Last Reviewed Date: September 21, 2016


Thank
you!