presidential address

Advances in Treatment of Loco-regionally Advanced Lung Cancer and the ACCP*
A Common Ground

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I begin by acknowledging the pleasure and honor which you, the members of the American College of Chest Physicians (ACCP), have provided me by allowing me to serve as the President of this prestigious society. I also ask your indulgence as I thank two special people. The first is Dr Alfred Soffer, well known to you as the Executive Director of the ACCP. Without Al's support I would not be in front of you, and without his counsel this eventful year would not have been as successful. I would also like to thank my wife, Louise, for her enduring support and stimulation. Any seeming accomplishment of mine is the result of a joint endeavor.

In this presentation, as suggested by its title, I will begin by updating you for the status of treatment of loco-regionally advanced non-small cell lung cancer. Great strides have been made, principally as a result of multispecialty and interdisciplinary efforts. This is precisely the spirit of the ACCP and identifies the common ground which will be the theme of the concluding half of this talk.

In precise terms, loco-regionally advanced non-small cell lung cancer means that there is stage IIIA disease present. By definition, this stage includes involvement of ipsilateral (N2) mediastinal lymph nodes and/or T3 primary tumors, which either invade into or through the parietal pleura or are centrally located within the tracheobronchial tree. Figure 1 illustrates the staging definitions of the American Joint Committee on Cancer (AJCC). As recently as ten years ago it was fully accepted that involvement of what we now call N2 mediastinal lymph nodes, as distinct from N3 or contralateral mediastinal lymph nodes, was equivalent to metastatic involvement of distant organs and represented a clear contraindication to a curative approach.1,2 There was a bit more optimism in the approach to patients with lung cancers with local invasion through the visceral pleura, but even here there were definite pockets of pessimism within the medical community, strongly voicing the belief that a curatively based approach was futile. Of relevance and worth emphasizing is the observation that the orientation of the attack on lung cancer and proclamations regarding therapy were within specialties. Reports were issued by thoracic surgeons or radiation therapists or medical oncologists and failed to incorporate or appreciate the experiences from the other specialty groups.

Over the last decade, significant progress has been made in the treatment of stage IIIA non-small cell lung cancer. The literature now abounds with, and society meetings such as ours enjoy the benefits of, interdisciplinary reports and presentations of therapeutic advances in this area. These advances are clearly the result of interdisciplinary and collegial approaches. An archetypal example is the Chest Oncology Group at the University of Chicago, in which I had the opportunity to participate. This type of institutional approach and commitment to lung cancer patients, which is now pleasingly widespread, incorporates thoracic surgeons, medical oncologists, radiation therapy oncologists, and pulmonologists in a forum which addresses the patient and his lung cancer in a comprehensive and integrated fashion. Clinical strategies for diagnosis, staging, and treatment are based on interdisciplinary analysis and considerations and...
Involvement of ipsilateral mediastinal and/or subcarinal lymph nodes

**FIGURE 1.** Illustrations of AJCC definitions of T3 primary lung cancer (*top*) and N2 mediastinal lymph node involvement (*bottom*).

are arrived at through open discussion. There is no question in my mind that this approach provides the best care for individual lung cancer patients and facilitates advances in therapy.

This latter point is emphasized by many recent reports of experiences with a multimodality approach to patients with stage IIIA lung cancer. Using preoperative cisplatin-based combination chemotherapy regimens followed by a carefully orchestrated sequence of surgical resection and/or radiation therapy, improved results compared to historical experiences are now achieved in many centers. The chemotherapy arm of this coordinated approach typically achieves a greater than 50 percent complete or partial clinical response without significantly worsening the operative mortality or morbidity. These reports consistently document that these multimodality regimens produce a 30 percent to 50 percent actuarial five-year survival rate for patients with advanced loco-regional disease. These data should be compared with the 10 percent to 20 percent range for five-year survival reported a few short years earlier. As emphasized by others, the final proof of the potential advantage of these approaches awaits conclusive results from the phase III studies presently ongoing, which prospectively and simultaneously compare randomized therapeutic al-
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IN THE
Supreme Court of the United States

OCTOBER TERM, 1990

THOMAS CIPOLLONE, Individually and as Executor
of the Estate of Rose D. Cipollone,

v.

LIGGETT GROUP, INC.,
A Delaware Corporation;

PHILIP MORRIS, INC.,
A Virginia Corporation; and

LOEW'S THEATRES, INC.,
A New York Corporation,

Respondents.

On Writ of Certiorari to the United States Court of Appeals
for the Third Circuit

BRIEF OF
AMERICAN COLLEGE OF CHEST PHYSICIANS
AS AMICUS CURIAE IN SUPPORT OF PETITIONER

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Figure 2. Title page of the amicus curiae (friend of the court) brief submitted by the ACCP to the Supreme Court.

However, interdisciplinary and collegial approaches are clearly pointing the way to improved care of these patients.

What does this have to do with the ACCP? The answer lies in the philosophical framework within which this society functions—that is, a spirit of not just multidisciplinary, but rather interdisciplinary, activity. The membership includes pulmonologists, cardiologists, thoracic surgeons, intensivists, radiologists, pathologists, and medical oncologists. Hopefully and ideally, these specialists see the ACCP as a forum and an opportunity for interchange and discussion between, as much as among, the specific specialties.

As a thoracic surgeon, I do not come to our annual meeting to participate in a "mini Society of Thoracic Surgeons" meeting, but rather with the expectation that I will interact with other specialists and other specialties.

This philosophy is embodied in the bylaws of the ACCP. In particular, I refer to the requirement for the establishment of forums and sections within the forums. Specifically, section 12 of the bylaws specifies that "the several scientific sections shall be aggregated into scientific forums according to the specialties represented in each so that sections having like or reasonably similar interests will be associated in the same forum" (emphasis added). Clearly, the message here is that aggregations shall be according to commonalities of clinical interest rather than according to specialty orientation per se. Fellows are not limited in any way by their identification with a particular section or forum; hopefully and even presumably, they will have other interests and areas of involvement. The message is not restrictive in any way. The goal is to ensure simply that all activity and participation in College functions will be based on collegial and interdisciplinary interactions oriented around similar interests or involvement. In my own experience as a member of the Section on Cancer within the Forum of Pulmonary Disease, there was enormous benefit from the interaction of pulmonologists, thoracic surgeons, radiation therapists, radiologists, and medical oncologists. Without question, this approach has allowed development of the most effective postgraduate programs and educational sessions at the Annual Scientific Assembly. It has also led to a continuing series of state-of-the-art articles, published in *Chest*, on various aspects of lung cancer.

Another concrete example of the effectiveness of this interdisciplinary approach is the College's development and submission this year of an amicus curiae brief for the case before the Supreme Court of Cipollone v. Liggett et al (Fig 2). An interdisciplinary group of cardiologists, pulmonologists, and thoracic surgeons worked together with the legal counsel of the ACCP and our executive director to develop this important contribution (Fig 3). Of the many submitted briefs, the ACCP's contribution was the only friend of the court brief which focused on the important medical issues of this case, which will allow the Supreme Court...
Court to comment on the liability of tobacco companies for disease caused by their product given the presence of a federally mandated warning on the cigarette package. The ACCP has emphasized that the warning was too little too late given the state of knowledge of the role of smoking in the etiology of lung cancer. Further, and most important, the *amicus curiae* brief emphasizes the inadequacy of any warning once nicotine addiction has occurred. Only an interdisciplinary group could have formulated this important brief, which therefore represents the College working at its best.

In summary, I submit to you that the ACCP is a vigorous and important society for us all. It is important specifically because it is a nearly unique forum for interdisciplinary and collegial activity in the arena of chest diseases. This is a spirit which must be encouraged and fostered as we move into the future if we are to provide the best care possible for our patients.

**REFERENCES**


