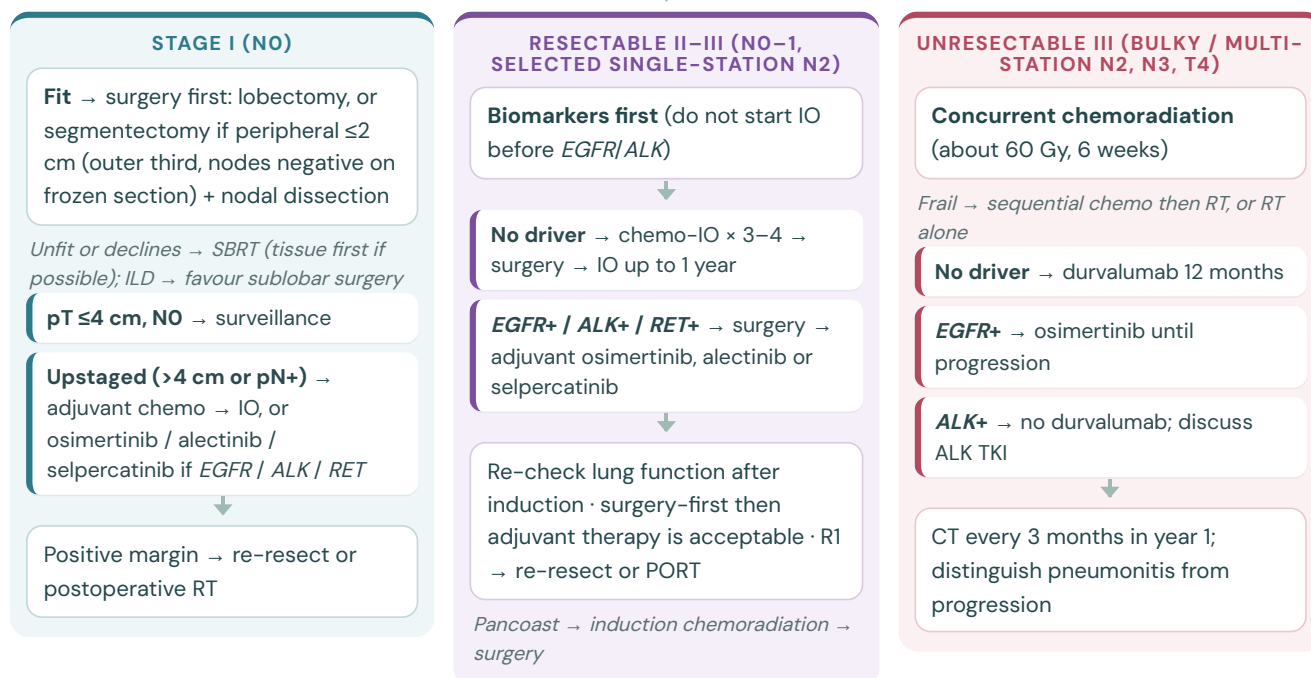


Lung Cancer: Non-metastatic NSCLC algorithm

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

Suspected lung cancer: contrast CT → biopsy that stages → histology, *EGFR/ALK/PD-L1* (NGS if possible) → PET-CT, brain MRI (stage II+), EBUS for nodes → lung function → tumour board



All patients: smoking cessation from the first visit; tumour board before treatment; lung-sparing surgery when oncologically adequate. Confirm PET-positive nodes with EBUS before calling a tumour unresectable.

Lung Cancer: Metastatic NSCLC algorithm

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New stage IV: tissue + NGS (DNA + RNA; plasma ctDNA if tissue is scant) · PD-L1 (22C3) · brain MRI · bone health · early palliative care

ACTIONABLE DRIVER

EGFR → osimertinib ± chemo, or amivantamab + lazertinib (gefitinib + chemo if cost-limited)

ALK → alectinib, lorlatinib or brigatinib

ROS1 → taletrectinib / repotrectinib
· **RET · MET ex14 · BRAF** → matched TKI · **NTRK** → TRK inhibitor or chemo-IO

KRAS G12C · HER2 mut · NRG1 → chemo-IO first; targeted drug next (zongertinib may come earlier for HER2)

Progression → re-biopsy or ctDNA

Oligoprogression → local therapy, continue TKI

Systemic → chemo ± amivantamab; small-cell transformation → platinum-etoposide

NO DRIVER: PD-L1 ≥50%

Pembrolizumab, atezolizumab or cemiplimab alone

Bulky, rapid or symptomatic → chemo-IO

Up to 2 years of immunotherapy

Progression → platinum doublet; IO rechallenge only if ≥6 months off treatment

NO DRIVER: PD-L1 <50%

Chemo-immunotherapy

Non-squamous → platinum-pemetrexed + pembrolizumab → pemetrexed maintenance

Squamous → carboplatin-(nab-)paclitaxel + pembrolizumab

PS 2 / elderly → single agent or carboplatin doublet; IO unaffordable → platinum doublet alone

Progression → pemetrexed (if unused) or docetaxel ± ramucirumab; HER2/c-MET protein → targeted ADC

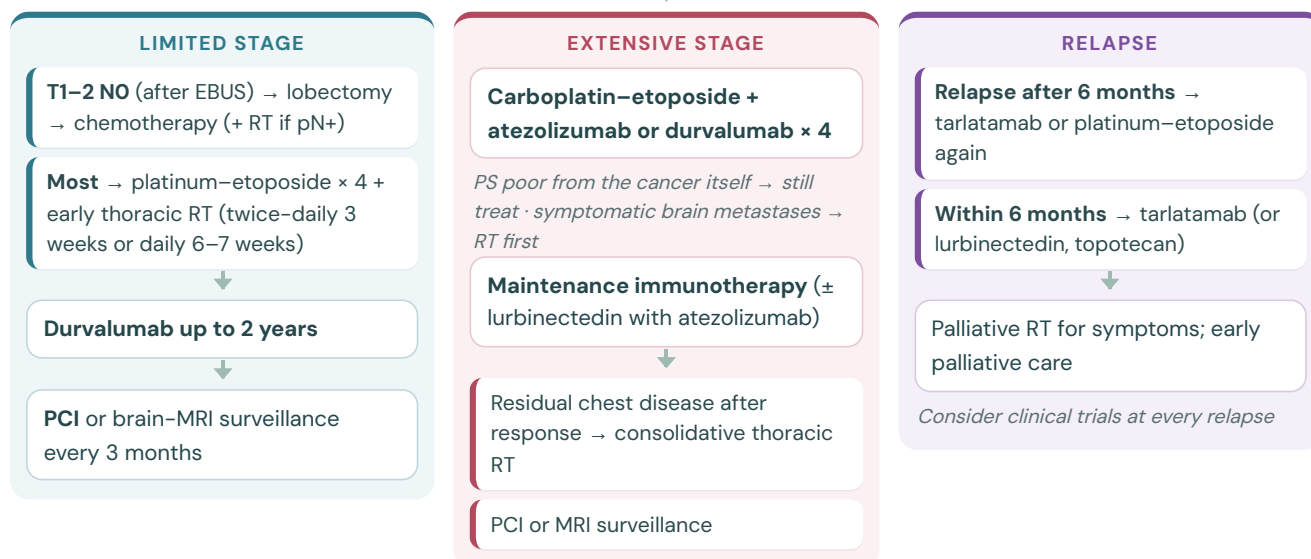
All patients: oligometastatic disease → consider consolidative radiotherapy or surgery · brain metastases → SRS (or TKI first if EGFR/ALK and asymptomatic) · bone metastases → bone-modifying agent · PS 3–4 without a driver → best supportive care.

Lung Cancer: Small cell lung cancer algorithm

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Confirm small cell histology (often from EBUS) → CT chest–abdomen or PET–CT · brain MRI · sodium, calcium · start treatment within days; treat SVCO, SIADH and cord compression urgently

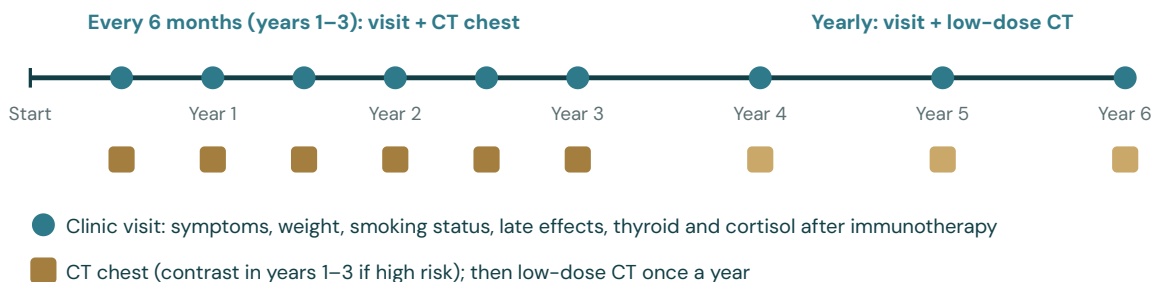


Small cell lung cancer can double in weeks: arrange treatment within days of diagnosis, and refer patients with poor performance status rather than excluding them.

Lung Cancer: Follow-up and survivorship plan

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Not routine when well: PET-CT, tumour markers (CEA, CYFRA 21-1), bone scan, brain MRI in NSCLC.

Small cell: closer review (every 2–3 months in year 1); brain MRI every 3 months in year 1 if no PCI was given.

A simple follow-up rhythm (NCCN, ESMO). After SBRT or chemoradiation, fibrosis can mimic relapse on CT: compare with earlier scans and biopsy before calling recurrence.

Reduce recurrence

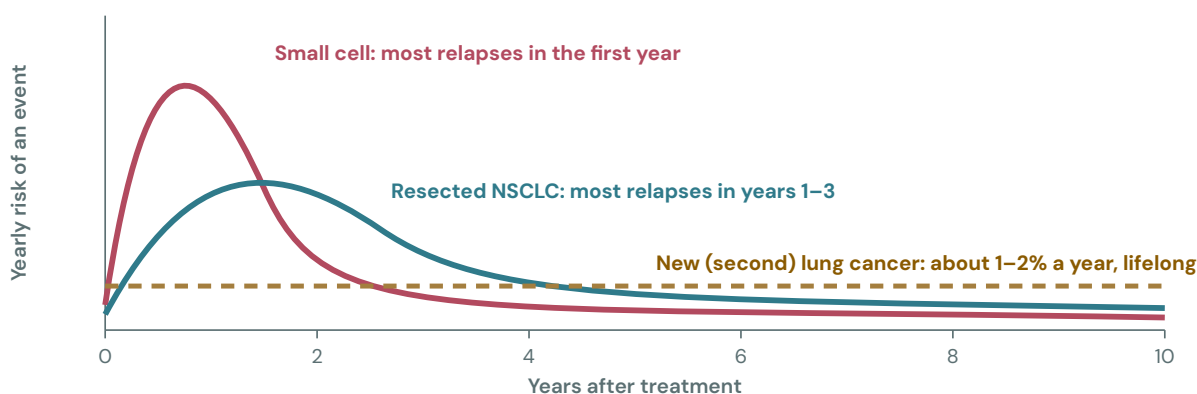
- Stop all tobacco (cigarettes, bidis, hookah); quitline 1800-11-2356
- Complete adjuvant or consolidation therapy; check TKI adherence
- Reduce household biomass smoke
- Pulmonary rehabilitation and exercise
- Yearly low-dose CT for second primaries

Red flags to report

- New or changed cough, haemoptysis, breathlessness
- Bone or back pain; leg weakness
- Headache, seizure, confusion, focal weakness
- Facial or arm swelling (SVC obstruction)
- Fever or cough on immunotherapy (pneumonitis)

Do not forget

- Thyroid and cortisol after immunotherapy
- Re-biopsy or ctDNA at TKI progression
- Brain MRI every 3 months in year 1 for SCLC without PCI
- TB reactivation: test a new cavity or effusion
- Vaccines: influenza, pneumococcal



When relapses happen, and when new cancers appear (illustrative shape, not to scale). Early follow-up looks for relapse; later follow-up looks for a new lung cancer, which is why stopping smoking and yearly CT continue.