Conversations with Oncology Investigators
Bridging the Gap between Research and Patient Care

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INTERVIEWS
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Roman Perez-Soler, MD
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STATEMENT OF NEED/TARGET AUDIENCE
Lung cancer is the leading cause of cancer mortality in the United States in both men and women, resulting in more deaths than breast, prostate, colon and pancreatic cancer combined. Progress in the screening, prevention and treatment of this disease has been modest, and about 85 percent of patients who develop lung cancer will die from it. In addition, a sense of therapeutic nihilism has pervaded the medical community in the past. Chemotherapy, surgery and radiation therapy have had modest effects on patient outcomes. However, recent improvements have been seen in time to progression and survival in lung cancer clinical trials. Published results from ongoing clinical trials lead to the continuous emergence of new therapeutic agents and changes in the indications for existing treatments. In order to offer optimal patient care — including the option of clinical trial participation — practicing medical oncologists, radiation oncologists, hematologists and hematology-oncology fellows must be well informed of these advances. To bridge the gap between research and patient care, Lung Cancer Update features one-on-one discussions with leading oncology investigators. By providing access to the latest research developments and expert perspectives, this CME program assists these physicians with the formulation of up-to-date clinical management strategies.

LEARNING OBJECTIVES
• Formulate an evidence-based algorithm for the use of adjuvant chemotherapy in localized NSCLC.
• Develop a treatment approach incorporating neoadjuvant chemotherapy and radiation therapy for patients with Stage III NSCLC.
• Evaluate the role of prognostic and predictive factors in selecting treatment for patients in the adjuvant and metastatic settings.
• Develop an evidence-based algorithm for first-line and later-line therapies in patients with advanced NSCLC.
• Assess the emerging clinical research data and ongoing trials evaluating the future roles of novel molecular targeted agents in lung cancer.
• Counsel appropriately selected patients about the availability of ongoing clinical trials for which they may be eligible to participate.

PURPOSE OF THIS ISSUE OF LUNG CANCER UPDATE
The purpose of Issue 2 of Lung Cancer Update is to support the learning objectives by offering the perspectives of Drs Kris, Perez-Soler, Brahmer and Bonomi on the integration of emerging clinical research data into the management of lung cancer.

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3 INTERVIEWS

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#### Tracks 1-2

**DR LOVE:** Can you discuss the recently published practice guidelines on adjuvant therapy developed by Cancer Care Ontario and the American Society of Clinical Oncology (Pisters 2007)?
**DR KRIS:** First I would like to point out the unanimity of the group in agreeing that adjuvant therapy — particularly adjuvant cisplatin-based chemotherapy — improves survival. It is important to deliver that message.

The devil is in the details. Agreement was reached that the data are strong for Stage II and Stage IIIA disease, and the guidelines represent a standard. However, in some areas the recommendations are not as strong. One of these areas is Stage IB disease — only one clinical trial specifically addressed that group (CALGB-9633), and it did not show a survival benefit (Strauss 2006).

In other adjuvant trials that did show a benefit — IALT, CAN-NCIC-BR10 and the ANITA trial — the primary endpoint was improvement in five-year survival for the entire study population. All those trials included patients with Stage IB disease, and they were all convincingly positive (Arriagada 2004; Winton 2005; Douillard 2006).

**DR LOVE:** How do you treat patients with Stage IB disease in your practice?

**DR KRIS:** I believe these patients should be offered adjuvant therapy, and I would probably offer it to patients with Stage IA disease also. Even with the new staging system, the five-year survival for these patients is such that we’d recommend adjuvant therapy if it were breast cancer.

**Track 4**

**DR LOVE:** What are your thoughts about ECOG-E1505, an ongoing trial evaluating three different types of cisplatin-based chemotherapy with or without bevacizumab?

**DR KRIS:** This trial evaluates cisplatin in combination with vinorelbine, gemcitabine or docetaxel, with or without bevacizumab (1.1).

We need to consider that this trial has a couple of caveats. One is our ability to administer each of those regimens. I expected that docetaxel/cisplatin might be superior because in the TAX-326 trial, that regimen showed improved survival and response over vinorelbine/cisplatin in the metastatic setting (Fossella 2003). However, we conducted two trials with the docetaxel/cisplatin regimen used in the ECOG trial, and while we thought it was a great idea, we were not able to deliver it.

The other caveat is the likelihood for greater myelosuppression when combining bevacizumab with chemotherapy, as seen in the Sandler trial, so we need to watch out for that (Sandler 2006).

**Track 14**

**DR LOVE:** What are your thoughts about nanoparticle albumin-bound (nab) paclitaxel in non-small cell lung cancer?

**DR KRIS:** The use of nab paclitaxel in breast cancer is fairly extensive, suggest-
ing that it is at least equivalent and probably better than paclitaxel. Additionally, it has one clear toxicity advantage, which is the lack of hypersensitivity reactions that are frightening to patients and, on rare occasions, can be lethal.

The other toxicities — alopecia, neutropenia and neurotoxicity — are comparable. To me, if good evidence of equivalence were available, with the safety advantage, nab paclitaxel would have an edge over the other taxanes.

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**DR LOVE:** What are your thoughts about the combination of an EGFR tyrosine kinase inhibitor like erlotinib with bevacizumab?

**DR KRIS:** Much empirical evidence supports that approach — they are two active agents with completely different side-effect profiles and mechanisms of action. Clearly it can be done, and many combine them routinely.

**DR LOVE:** In what clinical scenarios are they combined?

**DR KRIS:** Physicians use it as second-line therapy, although that was more common before bevacizumab was widely available. The safety of combining these agents is clear in the studies that have been reported (Herbst 2007; [1.2]). We also use the combination up front for some patients who are candidates for both agents.

It makes sense, particularly for a patient who has an EGFR mutation or a high likelihood of having an EGFR mutation, such as a woman who’s a never smoker. That patient has at least a 50-50 chance of having a mutation, and it makes sense to administer chemotherapy with bevacizumab and erlotinib.
**SELECT PUBLICATIONS**


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**DR LOVE:** What are your thoughts about the selection of a chemotherapy regimen to be combined with bevacizumab in advanced NSCLC?
DR PEREZ-SOLER: The AVAiL study results, reported at ASCO 2007, demonstrated that bevacizumab adds benefit to the cisplatin/gemcitabine chemotherapy regimen (2.1). Improvements in response rate and progression-free survival have been observed with the addition of bevacizumab (2.2).

The hazard ratios were good (Manegold 2007) but not as good as what was seen in ECOG-E4599, which evaluated the addition of bevacizumab to carboplatin/paclitaxel (Sandler 2006; [3.2, page 14]).

Initially, the premise was that bevacizumab would work independently of the chemotherapy used. I believe we are starting to learn that may not be true. Some chemotherapy regimens are better than others. For example, cisplatin/gemcitabine — which was used in AVAiL — may not be as good of a backbone as carboplatin/paclitaxel.

Some chemotherapeutic agents, particularly taxanes, are toxic to endothelial cells. They destroy blood vessels, which may help an anti-angiogenic agent and might explain why a taxane, at least in lung cancer, may be better. So it seems that a taxane-based regimen is probably a better option.

### 2.1 AVAiL Trial: Progression-Free Survival (PFS) with Cisplatin/Gemcitabine with or without Bevacizumab as First-Line Therapy for Patients with Advanced or Recurrent Nonsquamous NSCLC

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<th>Median PFS</th>
<th>Hazard ratio</th>
<th>p-value</th>
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<td>Cisplatin/gemcitabine + placebo</td>
<td>6.1 months</td>
<td>Reference</td>
<td>Reference</td>
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<td>Cisplatin/gemcitabine + bevacizumab 7.5 mg/kg</td>
<td>6.7 months</td>
<td>0.75</td>
<td>0.0026</td>
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<tr>
<td>Cisplatin/gemcitabine + bevacizumab 15 mg/kg</td>
<td>6.5 months</td>
<td>0.82</td>
<td>0.0301</td>
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**SOURCE:** Manegold C et al. Proc ASCO 2007; Abstract LBA7514

### 2.2 Update of the AVAiL Study: A Randomized Phase III Clinical Trial of Cisplatin/Gemcitabine with or without Bevacizumab in Patients with Advanced Nonsquamous NSCLC

“The update confirmed the clinically and statistically significant improvement in the primary endpoint of progression free survival (PFS) for the two different doses of bevacizumab studied in the trial (15 mg/kg and 7.5 mg/kg) compared to chemotherapy alone.

The study did not demonstrate a statistically significant prolongation of overall survival, a secondary endpoint, for either dose in combination with gemcitabine and cisplatin chemotherapy compared to chemotherapy alone. Median survival of patients in all arms of the study exceeded one year, longer than previously reported survival times in this indication.”

DR LOVE: What are your thoughts on bevacizumab/erlotinib?

DR PEREZ-SOLER: The data so far are encouraging. In the initial study by Roy Herbst with about 30 patients who failed at least one platinum-based regimen, the overall survival was one year with bevacizumab/erlotinib (Herbst 2005b). In CAN-NCIC-BR.21, the overall survival was about eight months for that group when treated with erlotinib alone (Shepherd 2005).

In the study by Fehrenbacher, bevacizumab added benefit to erlotinib (Herbst 2007; [1.2, page 6]). The good news was that this combination of two nonchemotherapeutic agents — bevacizumab and erlotinib — was superior to single-agent chemotherapy (docetaxel or pemetrexed).

Bevacizumab also added benefit to single-agent docetaxel or pemetrexed, so you could also combine pemetrexed or docetaxel with bevacizumab as second-line therapy for a better regimen (Herbst 2007).

However, the key issue is that patients who receive bevacizumab will receive it as front-line therapy. Once their disease has progressed, who will have the guts to keep pushing bevacizumab without data?

The BeTa trial, comparing erlotinib to erlotinib/bevacizumab, is being conducted only with patients who have never received bevacizumab as front-line therapy (2.3). It will probably be positive for the combination, but then the question will be how relevant this study is in practice because none of the patients in the trial received bevacizumab as front-line therapy.

I believe many people will conclude that it doesn’t mean anything. We need to determine whether bevacizumab is a good drug as second-line therapy for patients who have received bevacizumab as front-line therapy.

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2.3 BeTa: A Phase III Placebo-Controlled Randomized Study of Erlotinib with or without Bevacizumab as Second-Line Therapy for Advanced Nonsquamous NSCLC

Protocol IDs: OSI3364g, NCT00130728
Target Accrual: 650 (Open)

Eligibility
- Nonsquamous NSCLC with clinical or radiographic progression during or after first-line chemotherapy or chemoradiation therapy
- No prior therapy with an EGFR inhibitor or anti-angiogenesis agent

**Tracks 12-13**

**DR LOVE:** Can you review the RADIANT study?

**DR PEREZ-SOLER:** RADIANT is evaluating adjuvant chemotherapy followed by erlotinib administered for two years (2.4). It selects patients with EGFR-positive disease as determined by IHC or FISH.

The RADIANT trial is a good study for any patient who clearly has EGFR-positive disease. The issue will be whether a patient can receive erlotinib for two years — if that would be tolerable.

I believe it will be tolerable for most patients. The first two months may be rough, but after two months of erlotinib, the majority will find that the toxicity subsides and the skin rash improves. A minority will need a dose reduction or will not be able to tolerate the drug.

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## RADIANT: A Phase III Study of Erlotinib or Placebo with or without Adjuvant Chemotherapy for Patients with Resected, EGFR-Positive NSCLC

**Protocol IDs:** OSI-774-302, NCT00373425  
**Target accrual:** 945 (Open)

**Eligibility**
- Resected Stage IB to IIIA  
- EGFR-positive by FISH or IHC  
- ≤4 cycles of platinum-based chemotherapy (optional)

* Stratified by histology (squamous versus other), gender, age, EGFR status, smoking status and adjuvant chemotherapy


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**Tracks 15**

**DR LOVE:** Can you discuss the INTEREST study comparing gefitinib to docetaxel as second-line therapy?

**DR PEREZ-SOLER:** The trial met the noninferiority criteria (2.5) in that the curves were the same. The most interesting finding was that all the subsets that traditionally had been identified as good candidates for an EGFR inhibitor were also good candidates for docetaxel, as the nonsmokers and those with FISH-positive disease fared equally well with docetaxel as they had with gefitinib (Douillard 2007).
SELECT PUBLICATIONS


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**Select Excerpts from the Interview**

### Track 1

**DR LOVE:** Can you comment on predictors of response to EGFR TKIs?

**DR BRAHMER:** Some investigators believe that EGFR mutations are the major predictors of response, while others believe that EGFR gene expression, as measured by FISH, determines benefit from tyrosine kinase inhibitors. We know that patients treated with EGFR inhibitors will respond better if they have an EGFR mutation, but will they live longer? The large Canadian trial CAN-NCIC-BR21, which evaluated erlotinib versus placebo, retrospectively addressed this issue, and patients with EGFR mutations did not live any longer than those without the mutation when treated with erlotinib (Shepherd 2007). However, patients treated with erlotinib who had increased EGFR gene expression as determined by FISH did live longer (Shepherd 2007). Data from
the INTEREST study, evaluating gefitinib versus docetaxel, may reverse those findings (Douillard 2007).

The first-line trials evaluating erlotinib in patients with EGFR mutations will answer whether we should move erlotinib to the first-line setting for those patients. I don’t believe the mutations will indicate whether a patient will live longer with erlotinib versus another treatment, but those patients with EGFR mutations probably need erlotinib up front rather than chemotherapy.

**Track 4**

- **DR LOVE:** Can you discuss the data in NSCLC with vandetanib, which targets both the EGFR and VEGF pathways?

- **DR BRAHMER:** Dr John Heymach from MD Anderson has led much of the research on this agent and has presented interesting data combining chemotherapy and vandetanib. Vandetanib is both an anti-angiogenic and an inhibitor of EGFR, depending on the dose. Vandetanib at 100 milligrams per day has both anti-EGFR and anti-VEGF activity.

  The higher dose of 300 milligrams per day — at least when combined with chemotherapy — did not improve progression-free survival (Heymach 2007b; [3.1]). These findings have led to a large Phase III trial, which will be evaluating vandetanib at 100 milligrams per day with chemotherapy versus chemotherapy alone as second-line therapy.

<table>
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<td>Vandetanib + CP (n = 56)</td>
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<td>Median progression-free survival</td>
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<td>Men</td>
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<td>Women</td>
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<td>Median overall survival</td>
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<tr>
<td>Men</td>
<td>8.9 months</td>
</tr>
<tr>
<td>Women</td>
<td>≥8.6 months</td>
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</tbody>
</table>

**SOURCE:** Heymach J et al. *Proc ASCO* 2007b; **Abstract 7544**.

**Tracks 6, 8**

- **DR LOVE:** Can you provide an update on the ECOG-E4599 trial, which evaluated bevacizumab in advanced NSCLC (Sandler 2006)?

- **DR BRAHMER:** Patients with nonsquamous cell metastatic NSCLC were randomly assigned to first-line therapy with carboplatin/paclitaxel with or
without bevacizumab at 15 mg/kg. The patients treated with carboplatin/paclitaxel/bevacizumab experienced a significant improvement in overall survival compared to those who received chemotherapy alone (Sandler 2006; [3.2]).

However, in this study, elderly patients who were treated with chemotherapy and bevacizumab experienced increased toxicities with no improvement in survival compared to those treated with chemotherapy alone. For patients who are more prone to complications because of a drop in blood counts or any sign that they might be prone to bleeding, I would avoid using the three-drug regimen, not particularly because of age but certainly because of comorbidities, lower physical activity and the potential for bleeding.

**DR LOVE:** If you see a patient in his or her seventies who otherwise meets the criteria for E4599, do you have any hesitation about using bevacizumab?

**DR BRAHMER:** Absolutely not. I’d have more hesitation if they were in their fifties and had a history of active coronary artery disease or even leg claudication. I’d be more worried about those patients than the active 70-year-old with no other health problems.

### 3.2 ECOG-E4599: Efficacy of the Addition of Bevacizumab (B) to Paclitaxel (P) and Carboplatin (C) in Previously Untreated Metastatic Nonsquamous NSCLC

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</tr>
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<td>Overall response</td>
<td>15%</td>
<td>35%</td>
<td>—</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>


### SELECT PUBLICATIONS


Tracks 1-8

Track 1  Cisplatin/pemetrexed versus cisplatin/gemcitabine for chemotherapy-naïve patients with locally advanced or metastatic NSCLC

Track 2  Eligibility criteria in the selection of patients for treatment with bevacizumab

Track 3  Treatment algorithm for advanced NSCLC in nonsmokers with EGFR mutations

Track 4  Evolving clinical trial data with cetuximab in advanced NSCLC

Track 5  EGFR mutation status and clinical decision-making

Track 6  Ongoing clinical trial evaluating vandetanib in advanced NSCLC

Track 7  Clinical trials of chemoradiation therapy with biologic therapy for Stage III NSCLC

Track 8  ECOG adjuvant trial E1505: Chemotherapy with or without bevacizumab

Select Excerpts from the Interview

Track 1

DR LOVE: Can you describe the recent results of the trial evaluating cisplatin with either pemetrexed or gemcitabine in advanced disease?

DR BONOMI: As we move forward, chemotherapy will be used in different, more targeted fashions as was seen in the Phase III randomized study of pemetrexed/cisplatin versus gemcitabine/cisplatin.

This was a 1,700-patient study, of which approximately 1,200 patients had a nonsquamous cell diagnosis. A subset analysis of patients with adenocarcinomas and large cell histology reported significantly longer overall survival with pemetrexed versus gemcitabine (Scagliotti 2007; [4.1]).

It has always been said that histology doesn’t make any difference to the effectiveness of chemotherapy in relation to response or survival. These results flew in the face of convention and made everybody say, “Wait a minute.” Many people remain skeptical, but increasing data will suggest that pemetrexed works better in adenocarcinoma.
The hazard ratio was approximately 0.8, which wasn’t a home run. However, without doing anything differently except selecting the patients, there seems to be an advantage with pemetrexed (Hanauske 2007).

Treatment of Stage IV disease has always been about trying to relieve symptoms and prolong life. It is a testing ground for new ideas that we hope to move into earlier-stage disease — locally advanced disease and ultimately into the adjuvant setting — which we hope will translate into longer survival.

### 4.1 Randomized Phase III Trial of Cisplatin and Pemetrexed versus Cisplatin and Gemcitabine in Locally Advanced or Metastatic NSCLC: Efficacy Data

<table>
<thead>
<tr>
<th></th>
<th>Cisplatin + pemetrexed (n = 862)</th>
<th>Cisplatin + gemcitabine (n = 863)</th>
<th>Adjusted HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median overall survival (OS)</td>
<td>10.3 months</td>
<td>10.3 months</td>
<td>0.94 (0.84-1.05)</td>
</tr>
<tr>
<td>OS subset analysis*</td>
<td>11.8 months</td>
<td>10.4 months</td>
<td>0.81 (0.70-0.94)</td>
</tr>
<tr>
<td>Median progression-free survival (PFS)</td>
<td>4.8 months</td>
<td>5.1 months</td>
<td>1.04 (0.94-1.15)</td>
</tr>
<tr>
<td>PFS subset analysis*</td>
<td>5.3 months</td>
<td>4.7 months</td>
<td>0.90 (0.79-1.02)</td>
</tr>
</tbody>
</table>

* Patients with adenocarcinoma or large cell carcinoma; CP n = 512; CG n = 488

HR = hazard ratio; CI = confidence interval; CP = cisplatin + pemetrexed; CG = cisplatin + gemcitabine

DR LOVE: What’s your treatment algorithm for patients with advanced NSCLC who are nonsmokers or who have EGFR mutations?

DR BONOMI: We don’t know the answer yet, but I and many other people would treat such patients with an EGFR TKI first, then proceed to chemotherapy later. I wouldn’t administer them together, although some clinicians would consider using the combination.

I would treat with the EGFR TKI and evaluate the response. Not all patients respond, but they have a relatively high response rate — higher than with chemotherapy.

DR LOVE: For the patient who responds, what would you do after disease progression?

DR BONOMI: I would use chemotherapy with bevacizumab, if appropriate.

DR LOVE: Have you used erlotinib with bevacizumab?

DR BONOMI: Yes. In fact, I had a patient who had a large mass in his lung, multiple nodules, PS 1.5 and extensive bone metastases.

A friend advised him to opt for erlotinib and bevacizumab with no chemotherapy, and we did that. He had an unbelievable response and went into a remission for a year and a half.

SELECT PUBLICATIONS


QUESTIONS (PLEASE CIRCLE ANSWER):

1. Which of the following chemotherapy regimens are included in the ECOG-E1505 trial evaluating chemotherapy with or without bevacizumab for patients with completely resected Stage IB to IIIA NSCLC?
   a. Vinorelbine/cisplatin
   b. Docetaxel/cisplatin
   c. Pemetrexed/cisplatin
   d. Both a and b

2. In the randomized Phase III trial of pemetrexed/cisplatin versus gemcitabine/cisplatin, which regimen was superior in median overall and progression-free survival for patients with adenocarcinoma or large cell carcinoma?
   a. Pemetrexed/cisplatin
   b. Gemcitabine/cisplatin

3. The AVAiL trial demonstrated that the addition of __________ to chemotherapy as first-line therapy for NSCLC improved the response rate and progression-free survival rate.
   a. Erlotinib
   b. Bevacizumab
   c. Cetuximab
   d. Panitumumab

4. Vandetanib is a once-daily oral inhibitor of __________.
   a. VEGF receptor
   b. EGFR kinase activity
   c. Both a and b

5. The BeTa trial will compare erlotinib to erlotinib/bevacizumab as __________ for patients with advanced NSCLC.
   a. First-line therapy
   b. Second-line therapy
   c. Third-line therapy

6. The RADIANT study will evaluate adjuvant __________ with or without chemotherapy in patients with EGFR-positive disease.
   a. Erlotinib
   b. Bevacizumab
   c. Cetuximab
   d. Panitumumab

7. The INTEREST study demonstrated that __________ was equivalent to docetaxel as second-line therapy for NSCLC.
   a. Erlotinib
   b. Gefitinib
   c. Cetuximab
   d. Pemetrexed

8. In ECOG-E4599, the addition of bevacizumab to carboplatin/paclitaxel for patients with previously untreated metastatic nonsquamous NSCLC resulted in a significant two-month improvement in overall survival.
   a. True
   b. False

9. Recently published practice guidelines on adjuvant therapy developed by Cancer Care Ontario and the American Society of Clinical Oncology represent a standard for treatment of Stage II and Stage IIIA disease but not for Stage IB disease, for which recommendations are not as strong.
   a. True
   b. False

10. Bevacizumab administration is contra-indicated for patients with which of the following?
    a. Brain metastases
    b. Hemoptysis
    c. Anticoagulant therapy
    d. All of the above

Post-test answer key: 1d, 2a, 3b, 4c, 5b, 6a, 7b, 8a, 9a, 10d
Research To Practice is committed to providing valuable continuing education for oncology clinicians, and your input is critical to helping us achieve this important goal. Please take the time to assess the activity you just completed, with the assurance that your answers and suggestions are strictly confidential.

**PART ONE — Please tell us about your experience with this educational activity**

**BEFORE** completion of this activity, how would you characterize your level of knowledge on the following topics?

- ASCO practice guidelines for adjuvant therapy
- AVAIL and ECOG-E4599: Use of bevacizumab as first-line therapy
- Phase III trial results of cisplatin with either gemcitabine or pemetrexed for metastatic NSCLC
- Emerging role of EGFR inhibitors in the adjuvant and metastatic settings

**AFTER** completion of this activity, how would you characterize your level of knowledge on the following topics?

- ASCO practice guidelines for adjuvant therapy
- AVAIL and ECOG-E4599: Use of bevacizumab as first-line therapy
- Phase III trial results of cisplatin with either gemcitabine or pemetrexed for metastatic NSCLC
- Emerging role of EGFR inhibitors in the adjuvant and metastatic settings

Was the activity evidence based, fair, balanced and free from commercial bias?

- Yes
- No

Will this activity help you improve patient care?

- Yes
- No

Did the activity meet your educational needs and expectations?

- Yes
- No

Please respond to the following LEARNER statements by circling the appropriate selection:

- 4 = Yes
- 3 = Will consider
- 2 = No
- 1 = Already doing
- N/M = Learning objective not met
- N/A = Not applicable

As a result of this activity, I will:

- Formulate an evidence-based algorithm for the use of adjuvant chemotherapy in localized NSCLC.
- Develop a treatment approach incorporating neoadjuvant chemotherapy and radiation therapy for patients with Stage III NSCLC.
- Evaluate the role of prognostic and predictive factors in selecting treatment for patients in the adjuvant and metastatic settings.
- Develop an evidence-based algorithm for first-line and later-line therapies in patients with advanced NSCLC.
- Assess the emerging clinical research data and ongoing trials evaluating the future roles of novel molecular targeted agents in lung cancer.
- Counsel appropriately selected patients about the availability of ongoing clinical trials for which they may be eligible to participate.

What other practice changes will you make or consider making as a result of this activity?

What additional information or training do you need on the activity topics or other oncology-related topics?
EDUCATIONAL ASSESSMENT AND CREDIT FORM (continued)

Additional comments about this activity:

May we include you in future assessments to evaluate the effectiveness of this activity?
☐ Yes  ☐ No

PART TWO — Please tell us about the faculty for this educational activity

<table>
<thead>
<tr>
<th>Faculty</th>
<th>Knowledge of subject matter</th>
<th>Effectiveness as an educator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark G Kris, MD</td>
<td>4 3 2 1</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>Roman Perez-Soler, MD</td>
<td>4 3 2 1</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>Julie R Brahmer, MD</td>
<td>4 3 2 1</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>Philip Bonomi, MD</td>
<td>4 3 2 1</td>
<td>4 3 2 1</td>
</tr>
</tbody>
</table>

Please recommend additional faculty for future activities:

Other comments about the faculty for this activity:

REQUEST FOR CREDIT — Please print clearly

Name: ___________________________________________ Specialty: _______________________________

Degree: ☐ MD  ☐ DO  ☐ PharmD  ☐ NP  ☐ BS  ☐ RN  ☐ PA  ☐ Other ______

Medical License/ME Number: ___________________________ Last 4 Digits of SSN (required): ____________

Street Address: __________________________________ Box/Suite: _________________________

City, State, Zip: ________________________________________________________________

Telephone: __________________________________ Fax: ______________________________

Email: __________________________________________________________

Research To Practice designates this educational activity for a maximum of 3 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

I certify my actual time spent to complete this educational activity to be _________ hour(s).

Signature: ___________________________ Date: ___________________________

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