2026

DEBATES AND DIDACTICS in Hematology and Oncology

EMORY WINSHIP CANCER INSTITUTE
National Cancer Institute-Designated Comprehensive Cancer Center

Where Science Becomes Hope

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This activity is jointly provided by Partners for Advancing Clinical Education and Bio Ascend™

Patient-Based Panel Discussion Lung Malignancies

All Speakers: Drs. Gadgeel, Pan, Carlisle, Ramalingam, Steuer, Mamdani, Leal

Case Presented by Tyler Kristoff, MD

Initial Presentation

58-year-old woman

- Never smoker
- ECOG PS 0
- Progressive cough and dyspnea

Workup

- 4.2 cm RLL adenocarcinoma
- Mediastinal adenopathy
- Bilateral pulmonary metastases
- 3 asymptomatic brain metastases (largest 8 mm)

Molecular Testing

- EGFR L858R mutation
- TP53 co-mutation
- PD-L1 TPS 10%

Initial Management Discussion

The patient is highly functional and wishes to maximize long-term disease control. She is willing to accept additional toxicity if it meaningfully improves outcomes.

What is your preferred frontline treatment?

- Osimertinib alone
- Osimertinib + platinum/pemetrexed
- Amivantamab + lazertinib

Additional Questions

- Does the presence of brain metastases influence your choice?
- Does TP53 co-mutation influence your choice?
- Which patients still receive osimertinib monotherapy in your practice?

Case Variation: Uncommon / Compound EGFR Mutation

62-year-old never-smoker

- Metastatic lung adenocarcinoma
- ECOG 0
- Small asymptomatic brain metastases

NGS

- EGFR G719A
- EGFR S768I
- No additional actionable alterations

Discussion Point

- How do you approach frontline therapy for a patient with a compound EGFR mutation?

Patient 1 Clinical Course

Patient elects: **Osimertinib + carboplatin/pemetrexed**

Treatment response:

- Partial systemic response
- Complete intracranial response

18 months later:

- New isolated 1.5 cm liver metastasis
- Stable thoracic disease
- No CNS progression

Discussion Point

- How do you approach oligoprogression after frontline combination therapy?

Q&A