

The Future and Lung Cancer: Room For Optimism?

The readership of *Cancer Control* is surely aware of the dismal state of affairs in the treatment of lung cancer. Lung cancer is currently the leading cause of cancer deaths in both men and women in the United States. Deaths from lung cancer in women long ago surpassed those due to breast cancer. In 1999, an estimated 170,000 to 180,000 Americans were diagnosed with lung cancer, and 159,000 (an estimated 68,000 women and 91,000 men) died of this disease.¹ The number of deaths resulting from lung cancer exceeds the mortality from the next three most common cancers combined (colorectal, breast, and prostate).

The expected five-year survival for all patients diagnosed with lung cancer in 1999 was 14% compared with 63% for colon cancer, 85% for breast cancer, and 93% for prostate cancer.¹ The current five-year survival rate is only slightly better than the 8% survival rate of the early 1960s. However, one might take solace from the fact that 6% of 180,000 patients (or nearly 11,000 patients) will survive in 1999 who would not have survived in 1960. We must be doing something right, but we still have a long way to go. This issue of *Cancer Control* outlines some of those things that we are doing right.

Melvyn S. Tockman, MD, PhD, describes recent advances in the screening of sputum for early changes that might identify patients who will develop — or are at risk for developing — invasive lung cancer. In doing so, he provides support for a new look at screening and early diagnosis. Currently, screening for lung cancer is not endorsed by either national organizations or widely adopted clinical practice guidelines. Recent advances in the field of early diagnosis may provide some impetus to reconsider screening for lung cancer.

Benjamin Movsas, MD, also reviews the technologic and clinical advances in the delivery of therapeutic radiation for locally advanced or unresectable non-small cell lung cancer, including altered radiation fractionation schemes, radiation dose escalation, and combined chemoradiotherapy regimens.

Also in this issue, Francis D. Sheski, MD, and Praveen N. Mathur, MDDS, discuss the various treatment modalities deliverable by the bronchoscope. The identification of “early lung cancer” provides no advantage if we have little to offer the patient short of traditional therapy. These techniques, if feasible and result in comparable or enhanced outcomes, may be widely

applicable as they are less invasive and better tolerated. A significant amount of work remains, however, to verify the value of these techniques and methods.

It is disconcerting to note that the five-year survival for resectable lung cancer lesions is significantly less than 100% (stage IA = 67%, IB = 57%, IIA = 55%, IIB = 39%, and IIIA = 23%).² Speculation abounds regarding why this is the case and what might be done to address the problem. In their discussion of neoadjuvant approaches to the treatment of lung cancer, Thomas A. Hensing, MD, and colleagues discuss a promising approach to this dilemma.

Finally, while not minimizing the efforts of clinicians and clinical researchers, the “biggest bang for the buck” comes in the form of preventing lung cancer and, of course, we are talking about cigarette smoking. Whether primary, secondary, or tertiary, prevention has the biggest potential to improve the dismal statistics associated with this cancer. In this issue, J. Lee Westmaas, PhD, and colleagues provide a review of recent advances in smoking cessation techniques and methods that are pertinent to oncologic practitioners.

Despite an incredible amount of effort, lung cancer statistics in

2000 are still frightening and depressing. Nevertheless, there is some room for optimism. The authors contributing to this issue have provided some insights into the future that may be more encouraging for patients and physicians alike. I am pleased with this issue of *Cancer Control* and hope you will be also.

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