Multidisciplinary Perspectives on the Evolving Management of *EGFR*-Mutated Metastatic NSCLC

Interviewees:

Jacob Sands,[1] Beth Sandy,[2] Stefanie Houseknecht[3]

1. Dana-Farber Cancer Institute, Boston, Massachusetts, USA
2. Abramson Cancer Center, University of Pennsylvania, Philadelphia, USA
3. Johns Hopkins Bayview Medical Center, Baltimore, Maryland, USA

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Interview Summary

This educational podcast from AMJ explored multidisciplinary perspectives on the evolving management of *EGFR*-mutated metastatic non-small cell lung cancer (NSCLC) with three expert speakers: Jacob Sands, Thoracic Medical Oncologist at the Dana-Farber Cancer Institute in Boston, Massachusetts, USA; Beth Sandy, Nurse Practitioner in Thoracic Medical Oncology at the University of Pennsylvania's Abramson Cancer Center in Philadelphia, USA; and Stefanie Houseknecht, Clinical Pharmacy Specialist for thoracic malignancies at Johns Hopkins Hospital and Bayview Medical Center in Baltimore, Maryland, USA. Experts highlighted the increasing complexity of managing *EGFR*-mutated metastatic NSCLC, emphasized the importance of multidisciplinary collaboration in treatment planning and patient support, and discussed key factors and real-world challenges that can shape clinical decision-making.

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COMPLEX TREATMENT LANDSCAPE

By sharing their perspectives on the current treatment landscape for *EGFR*-mutated metastatic NSCLC, experts highlighted meaningful changes in how patients are managed today compared with several years ago.

"I think complicated is the first word that comes to mind," remarked Sands, "and that's actually a good thing."

"It's complicated because we have so many treatment options that actually require a very individualized patient discussion around the options that are available in each setting," he continued. "Even from first line to second line, potentially even third line, there are options to consider. So, it's complicated, but because of the advances we've had in the field."

Building on this, Sandy highlighted the increasing importance of comprehensive, early molecular assessment in NSCLC management, which reflects a broader paradigm shift in the field towards precision medicine.[1] "Our biomarker testing has really improved over the past 5–10 years and we are identifying more patients now, with not just *EGFR*, but with different types of *EGFR* mutations," Sandy explained.[2] "That's exciting," she noted, because "identifying more patients then leads to more treatment options for those patients."

Experts collectively acknowledged that these advances in disease management over time have also led to increasing treatment complexity in *EGFR*-mutated metastatic NSCLC.[3] Clinicians must now consider not only treatment planning, but management of patient expectations and optimization of the patient experience.

THE CRITICAL ROLE OF MULTIDISCIPLINARY TEAMS

Multidisciplinary teams (MDT) play a critical role in the management of patients with advanced NSCLC, and a coordinated, collaborative approach is critical to shaping treatment strategy and optimizing clinical outcomes.[4,5] Experts also noted that this cross-disciplinary collaboration has assumed increasing importance as treatment pathways grow more complex.

Outlining the different roles within the MDT, Sands described medical oncologists as "the point person" in interacting with the patient, as well as the lead in directing overall treatment decision-making. "As an oncologist, it's really important for me to make sure that I'm touching base with all team members and that I'm really welcoming that input from everybody else as well," he emphasized, "because sometimes they're getting very different input from the patient; that just kind of naturally happens with the different roles played in care."

As an example, Sands highlighted the key role of infusion nurses who handle the administration of subcutaneous and intravenous treatments for patients with advanced NSCLC. "Patients often talk differently with the nurses than they do with the physician," he explained. "Patients will put on a good face for their oncologist but then sometimes they go back to the infusion room and say: 'Oh, here's what's really going on.'"

Sandy confirmed that nurses across all levels have a pivotal role to play within the MDTs involved in managing patients with *EGFR*-mutated metastatic NSCLC, providing vital patient support and helping to ensure treatment continuity. "My role as a nurse practitioner is to see patients in clinic when they're coming back for routine treatments, when they're not due for scans, and to help manage their toxicities, and also prescribe their treatment," she outlined.

From the clinical pharmacist perspective, Houseknecht explained that her role is focused primarily on medication access, education, and adherence monitoring. "If the oncologist is making a treatment plan, that plan is only good to the patient if we can actually get the regimen affordable

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and covered so that the patient doesn't experience financial toxicity, which is an increasing concern as the cost of therapies increases," she stressed.

Houseknecht also highlighted the important part played by pharmacists in providing ongoing supportive care and monitoring to patients. "For patients on oral therapies, the beauty of that is that it allows the patient to go and live their life. They may only see the oncologist every 3 or 4 months if they've been on therapy for a while," Houseknecht explained. "However, we know that toxicities can pop up in between those visits, and so I do a lot of telephone-based outreach to patients, via MyChart® (Epic Systems Corporation, Verona, Wisconsin, USA), other platforms, or electronic messaging systems, to make sure that patients are still doing well, they still have access to their medication, and they're still tolerating it." She added: "If I identify any issues, I will bring those back to the team so that we can address them as a group."

In her role as advanced practice provider, Sandy also emphasized how different members of the MDT can support and enhance the role of their colleagues. "I am so lucky to have a clinical pharmacist working next to me," she said. "That ability to help me with drug–drug interactions, getting access to these medications, prior authorizations, and then having someone on the back end, making sure that the patient is taking these medications properly, if they are oral."

"That has really enhanced my ability to focus on seeing patients in clinic, managing toxicity, and helping them through the logistics of it," Sandy highlighted.

IMPACT OF EARLY TREATMENT DECISION-MAKING

As the therapeutic armory for advanced NSCLC continues to expand, oncologists face more challenging decisions around treatment sequencing within the context of longer-term disease management.[6] Early treatment decisions can prove particularly consequential in *EGFR*-mutated metastatic NSCLC given the downstream impact of first-line choices on patients' overall treatment journey.[6]

This important concept of early treatment selection and treatment sequencing intent was reinforced by Sands. "Given that there are so many different treatment options in the first line, second line, and, possibly, third line, that first-line decision has implications [...] and so it needs to be a personalized discussion with patients," he advised. "There are toxicity profile differences, and it is also dependent upon patients' preferences and circumstances as well."

Sands underscored: "It does take a bit of a complex discussion at the very beginning, because there are downstream implications to the next line of therapy."

In initial visits with newly diagnosed patients, Sands highlighted the challenges for the medical oncologist in laying out the various treatment options and the need to "help patients get their feet on the ground," so they can become active and informed participants in their own treatment selection. "Part of the skill of this discussion with patients is recognizing when they're not getting anything, when their eyes are glazed over, and you can tell that just the room is spinning so much that they're not capturing things," he explained. "So, part of having this personalized discussion is recognizing where patients are mentally as this discussion is happening and trying to meet them where they're at."

PATIENT EDUCATION AND EXPECTATION SETTING

A key role of the advanced practice provider lies in delivering longitudinal support to patients, including managing side effect expectations, reinforcing the importance of consistent therapy, and addressing concerns between clinic visits.[7] When asked how patient education and expectation-setting

influence treatment and persistence over the duration of therapy, Sandy noted: "I think now, with the internet and AI, patients often come in with some expectation and some understanding of what their treatment may be."

Sandy continued: "One thing that I do have to remind patients of is that this is not something that you will be on for a few months and then stop. This is something that you are going to stay on, and that creates some planning, and the caregivers have to be prepared for that. Patients also need to prepare for potential toxicities."

"Just setting those expectations up front can be very helpful," she summarized.

"When talking with patients, it's so important to get a sense of what it is that's driving them, what it is that they're worried about, and then being able to specifically address that," added Sands.

INDIVIDUALIZATION OF CARE

Experts explained that management of NSCLC is increasingly moving towards an individualized approach to treatment that reflects heterogeneity in key clinical factors such as mutation subtype, disease burden, and comorbidities, as well as patients' own individual preferences.[3,8,9] "We have to remember that we are treating patients, and the patients' goals, their desires, and what is important for them must be at the forefront," stressed Sandy. "What is important to me might be very different than what is important to the patient."

From their unique position within the MDT, experts discussed key patient-specific and clinical factors that guide decisions around treatment intensity and use of combination therapies in *EGFR*-mutated metastatic NSCLC. "I think in the first-line setting, combination therapy in some form would be recommended," noted Sands.[3,9] "With that being said, the balance is going to be toxicity profile, comorbidities, and then the logistical component. And all of these together factor into a patient making a decision."[10]

When integrating potential adverse events (AE) into treatment decision-making, Sands stressed that "the differing toxicity profiles between different regimens is very important to discuss in a real, tangible way for patients."

"However, it is hard because we are talking about population-level data," he acknowledged. "We cannot know exactly what is going to happen for any one individual, but we know what the general toxicity profile is. For example, if this is a patient who plays guitar, where sensation in their fingertips is going to be really important, then that has implications."

All experts also agreed that logistical considerations play a vital, but often overlooked, role in steering management decisions in *EGFR*-mutated metastatic NSCLC. "We need to consider what does the patient have access and resources to," Sandy explained. "Some therapies require more treatment visits, more time away from work, more time away from the home," added Houseknecht. "Those are things that should be told to the patient upfront so that when they are engaging in that shared clinical decision-making, they have that information available."

"That's the part that doesn't show up in the presented data or in the manuscripts, but it is very individual for patients," emphasized Sands. "What does it take to get into the clinic and how frequently are patients required to come in?"

Finally, Sandy pointed out: "Clinical factors, whether or not the patient has brain metastases, which we know is common with *EGFR*-mutated NSCLC, may sway one treatment versus another."[11] In addition to performance status and age, "which type of *EGFR* mutation they have may also point us in one direction versus the other," she added.[2,3] "These are things that we are going to take into account when managing patients."

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When navigating trade-offs in the overall patient experience, Sands explained that "for the overall patient experience, it's not just toxicity profile and time in the infusion room, it's how long it's going to take patients to get there, who in their family is going to need to take off work to bring them, and the logistics around that."

"And so, factoring all of that together, we personalize a patient deciding which is the best regimen for them, given all those clinical and non-clinical factors," he summarized.

ADVERSE EVENT MANAGEMENT

Within the MDT overseeing treatment of patients with NSCLC, the pharmacist's expertise in medication management can play a key role in organ system-based AE management, including AE anticipation, grading, and monitoring, as well as assessing for potential drug–drug interactions.[12,13] Houseknecht explained how these supportive care and monitoring considerations have become increasingly important as treatment regimens for *EGFR*-mutated metastatic NSCLC grow more complex.[3] "All epidermal growth factor receptor (EGFR) inhibitors have some dermatologic toxicity," she acknowledged, making it important to help patients understand "what are things that can potentially make dermatologic toxicity worse, and what are things that can help ameliorate some of that dermatologic toxicity."[14]

"We're talking about a population that's typically older, because cancer is still a disease of aging," Houseknecht continued. "So, cardiotoxicity is a concern and something we need to monitor for, and make sure patients know what symptoms to report."[15] Finally, as thoracic practitioners, Houseknecht also mentioned the need to consider pneumonitis as a potentially rare AE associated with the treatment of *EGFR*-mutated NSCLC, noting that risk differs depending on the specific regimen.[16]

Above all, Houseknecht emphasized the importance of empowering patients by providing the tools needed to manage potential treatment-related toxicities. "I want all of my patients to feel that they can take matters into their own hands and know when it's important to call us to escalate things when they are no longer able to comfortably or safely control things at home," she remarked. In particular, Houseknecht stressed that it is vital to ensure "patients know when to report concerning symptoms and know how to get a hold of the clinic, and to make sure that our clinic team knows how to escalate urgent toxicities and manage those appropriately."

As part of the AE management for patients with *EGFR*-mutated metastatic NSCLC, a collaborative team-based approach, involving other clinical specialties where required, continues to be pivotal. "Sometimes this means engaging with colleagues outside of oncology to really bridge that gap," Houseknecht advised. As an example, she highlighted the "growing field of cardio-oncology," which is designed to address "the ways in which the therapies that we give can exacerbate pre-existing cardiovascular conditions, and how we can safely keep patients on therapy."[17,18]

ADDRESSING PATIENT PERCEPTIONS

Experts acknowledged that patients with EGFR-mutated metastatic NSCLC can often present with preconceived ideas, garnered from the internet, family, or even their own prior experiences, that may create fear or hesitancy towards particular treatment approaches. They suggested specific communication strategies which can be used to improve patient understanding and support shared decision-making in patients with these pre-existing perceptions or concerns.

"We all know the word chemotherapy can sometimes be upsetting to patients," recognized Sandy, "and it feels like

everybody knows somebody from 20 years ago who had chemotherapy and had a horrible experience."

"So, I like to reassure patients that chemotherapy in 2026 may be similar drugs, but we have much better supportive care strategies now," she explained.[10] "We have a better understanding of these medications and how to manage patients."

"For chemotherapy, a lot of patients assume that they're going to be laid up in bed vomiting without hair," agreed Sands. However, he pointed out that with platinum-based therapies, "the likelihood of nausea and vomiting may not be as high as what most people expect, but that's not true for everybody."[19]

"Some of it is trying to focus the discussion based upon the range of AEs patients are expecting, and then how to broaden that," Sands explained, disclaiming the occurrence and severity of adverse events differ between patients and cannot be predicted for any individual.

Similar to chemotherapy, Sandy noted that patients may be aware from the internet of some of the potential side effects of *EGFR*-targeted therapies used to treat NSCLC.

"I reassure them that we really do have good management strategies now," she stated, "and we can always reduce doses if they are having trouble."[14]

Houseknecht agreed with this approach to patient expectation management advocated by her MDT colleagues. "I start off by telling every patient: 'Let's take it one day at a time'," she explained. "No plan is unchangeable, and if we need to make modifications, we can do so."

"But that requires open lines of communication," Houseknecht added. "The patient needs to communicate to us what's going on and what's bothering them. And then we, in turn, need to work to the best of our ability to maximize supportive care and to make sure that patients are feeling well supported and that we're trying to reduce the impact that toxicity has on them."

"I think the other thing to remember is that the sheer amount of information that these patients are getting and is being delivered to them can be overwhelming," Houseknecht cautioned. "And so, I always ask a patient if they have a care partner or a family member or someone else who I can help to engage in the education and conversation."

Houseknecht explained that during their initial appointment with the medical oncologist, patients may only absorb a fraction of the total information that is shared. "That's where the advanced practice providers, the pharmacists, and the infusion center nurses can really fill in some of those gaps," she advised. "To make sure that patients have not only heard the information, but they have absorbed and understood it, and really feel empowered to be engaged, active members in their care."

CHALLENGES IN TREATMENT SELECTION AND SEQUENCING

In the management of NSCLC, as in other areas of oncology, real-world considerations such as logistical issues, access barriers, and coordination challenges can impact clinical decision-making.[6,10] Experts explored some of the key practical challenges that may be encountered when considering treatment selection and sequencing across the *EGFR*-mutated, metastatic NSCLC journey.

Houseknecht highlighted biomarker testing as a specific challenge related to treatment sequencing.[1] "Because once a patient is starting to progress on our first-line therapy, we are going to want to get as much information as possible to help us choose the most effective second-line regimen for that patient," she explained.

Houseknecht also flagged potential logistical issues around re-biopsying.[20] "We often have

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to present these patients to our MDT, engage interventional pulmonology, interventional radiology, and find out whether there is a high likelihood of getting viable tissue to be able to do biomarker testing [...] or, when we can't get tissue-based biomarker testing, potentially liquid biopsy," she explained.[21,22]

"The other consideration is clinical trials," Houseknecht continued. "We always want to keep in mind that we want a patient to be a candidate for, and to have the option to be offered, clinical trials. And so, sometimes we need to be thinking about that one step ahead."

"When we're thinking about sequencing therapies, we also need to keep in mind what's available locally that the patient would potentially be able to have access to," she advised. "Because we really do want to make sure that patients are candidates for later lines of therapy should their first-line regimen stop working."

"The challenges are different dependent upon the regimen," Sands confirmed, "and so, it comes down to really outlining each of those and managing the different toxicity profiles, given that there are more things to manage with some regimens than with others."[9,10]

MANAGING UNCERTAINTY

For the final segment of this educational podcast, experts discussed how the MDT can continue to improve care for *EGFR*-mutated metastatic NSCLC, communicating uncertainty to patients while still supporting shared decision-making.

"The shared decision-making is really key here in the *EGFR*-mutated NSCLC space," expressed Sandy. "There are a myriad of different treatment options that patients have now and that we must present to them."[3,10] She explained that toxicity profile and logistics weigh more heavily on the eventual treatment choice for some patients, while others will simply defer to the clinicians' opinion as to the best treatment approach.

Picking up on this point, Sands stressed that clinicians should guide and inform, but not dictate, patients' treatment decisions. "You're having an influence on what that patient is deciding and it's important for us also to take a little bit of a step back and outline these in a way that is as accurate as we can be, but then have no judgments about what patients are deciding within that context," he advised. In this way, Sands explained that shared decision-making can be "truly personalized, rather than just steering patients into something and then saying that's what they've chosen."

All experts acknowledged that the unpredictability of treatment outcomes in *EGFR*-mutated metastatic NSCLC creates challenges in how to communicate this uncertainty to patients with candor and compassion. "We don't have crystal balls, and we don't have the ability to predict the future," conceded Houseknecht.

Sands agreed: "In talking with patients, a really big topic is how to tell them what to expect while not narrowing it so much that you're completely wrong. So often, we get questions that are essentially patients saying, 'what's going to happen to me?'"

"I often frame that with telling them, first of all, any question they ask, I'm going to answer absolutely as bluntly as I possibly can," explained Sands. "That being said, some of these questions, there is not a one-line answer to."

When discussing potential treatment-related toxicities, Sands advised focusing on the most common expectations and scenarios from the 'long list' of potential AEs. "Similarly, my conversation with patients about how things will go has evolved quite a bit now," he continued. "When patients ask about how long this treatment is going to work or how long am I going to live,

these types of things, I now frame that as: 'Truthfully, the most accurate [answer] I can give you is just a range of possibilities.'"

EMOTIONAL ASPECTS OF CARE

As a core element in improving overall MDT care, experts also emphasized the emotional considerations when managing patients with *EGFR*-mutated metastatic NSCLC. "At the end of the day, we are taking care of people and human beings and not statistics, so that's really important," stressed Sandy.

"I think one of the things that's so challenging is that we are all aware of our mortality," explained Houseknecht. "We just don't know when that's going to be, so helping patients to process that is important."

"We're at work, but this is their lives," stressed Sands. "For someone to get a diagnosis that changes mortality from something that's intellectually known to now something that patients feel in their lives, that's a very big thing, and I don't know that anyone really fully processes that."

"When I'm talking with patients, I try to be really attentive to this," he continued. "I'm not just discussing manuscripts and data, I'm interacting with someone who now feels their mortality. That is a whole different space. So, how do I meet them where they are and then give them information that's meaningful?"

In instances where patients are clearly struggling to accept their diagnosis and treatment plan, experts advised engaging wider members of the collaborative MDT. "We do need to recognize when it's particularly important to bring in other subspecialists," said Sands. "When they're not processing well, help to get them resources, engage with social workers and with support groups," added Houseknecht.

Sands also highlighted the differences that may be observed in how patients respond emotionally to an NSCLC diagnosis. While many patients experience the disorientation of the diagnosis and difficulty processing everything, "there are some patients that approach this in a functional way, and then everything I'm saying is relevant," noted Sands. "And there are others that are feeling completely lost and are really having trouble doing anything in their lives, because this has become so big for them."

"It is really about emphasizing that you are treating a human being, a person, and an individual," Houseknecht reiterated.

CONCLUSION

The management of *EGFR*-mutated metastatic NSCLC is continuing to advance, with an expanding number of treatment options and different therapeutic approaches in the clinical arsenal. Multidisciplinary collaboration plays an increasingly important role within this evolving treatment landscape, helping to optimize therapy selection and sequencing, and provide vital support and education to patients as they navigate their chosen treatment pathway.

"The number of individuals that touch a patient from diagnosis until end of life is huge, and those people all play a really important role in their care and their journey," Houseknecht concluded.

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