

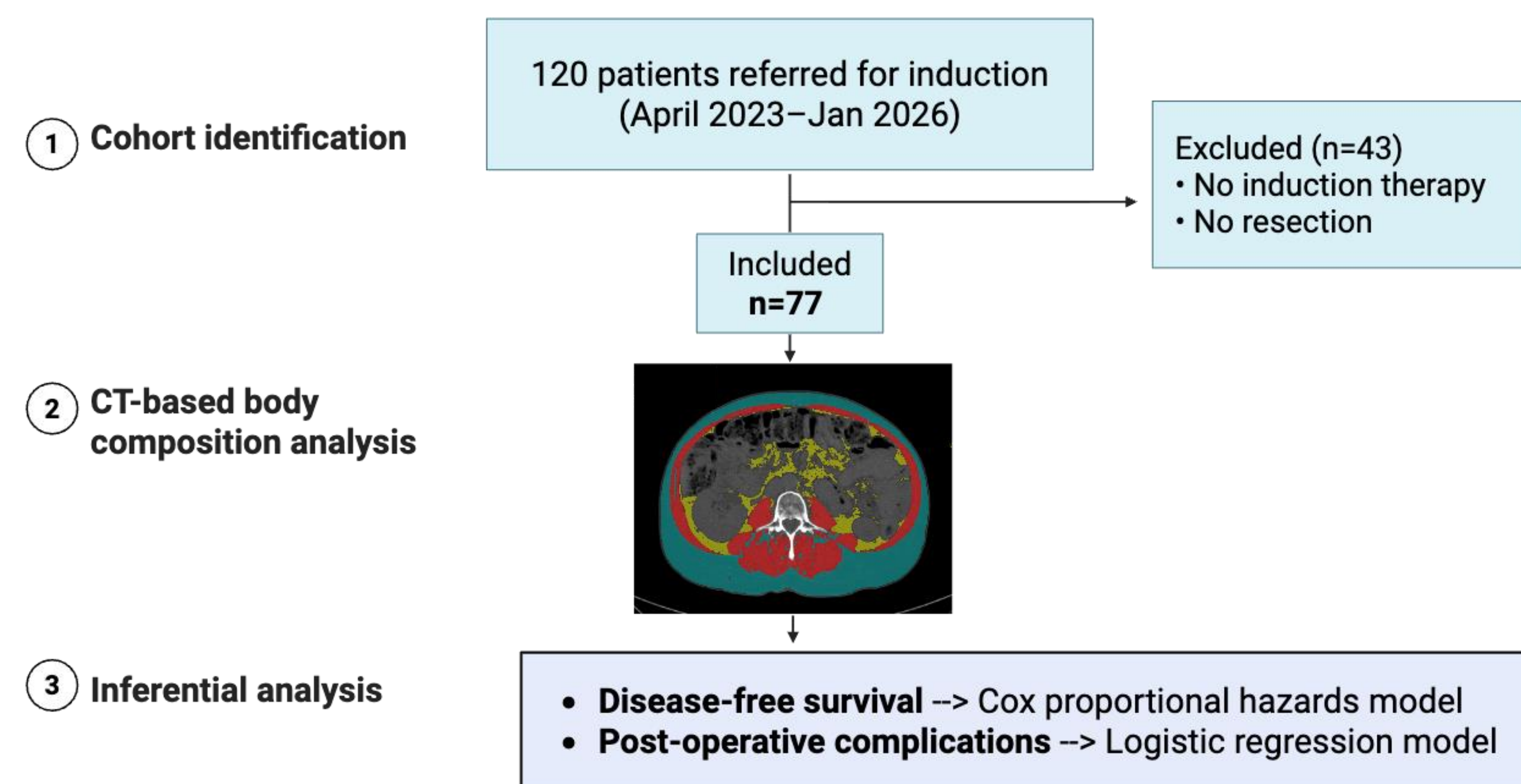
INTRODUCTION

- Induction chemo-immunotherapy has improved outcomes in locally advanced NSCLC
- Risk stratification within this novel treatment pathway is immature
- Body composition analysis is a promising but underexplored prognostication strategy

REFERENCES

- Prado CM et al. Prevalence and clinical implications of sarcopenic obesity in patients with solid tumours of the respiratory and gastrointestinal tracts: a population-based study. *Lancet Oncol.* 2008;9(7):629-635.
- Seely AJ et al. Systematic classification of morbidity and mortality after thoracic surgery. *Ann Thorac Surg.* 2010;90(3):936-942.

METHODOLOGY



DISCUSSION AND CONCLUSION

- Sarcopenic patients have an increased hazard of disease recurrence or death**
- Sarcopenic obese patients demonstrated a trend towards an increased odds of major post-operative complications or 90-day mortality**
- Prospective studies are needed to confirm results and to assess the integration of body composition analysis into clinical decision making and the impact on patient outcomes**

RESULTS

Figure 1

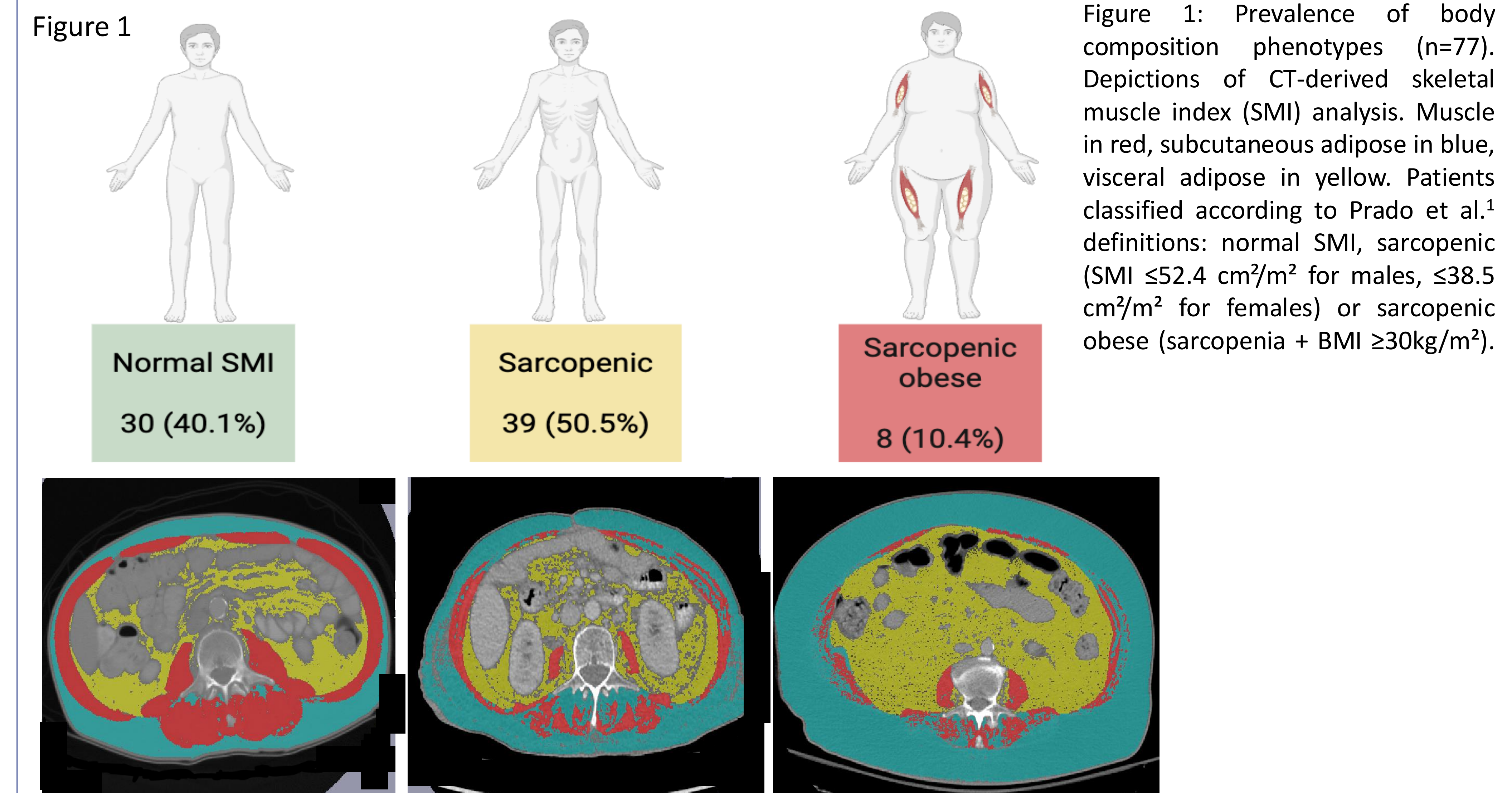


Figure 2

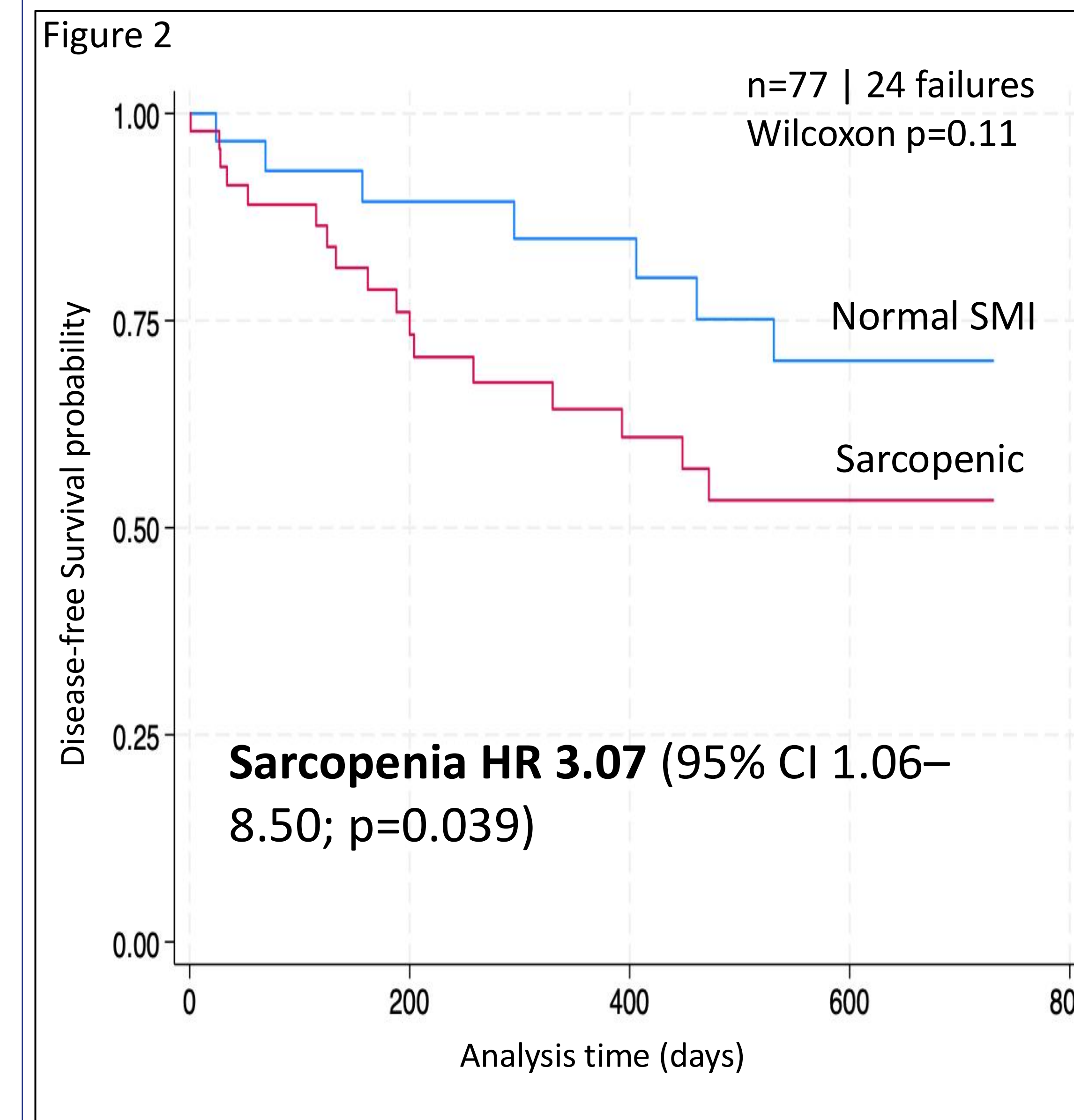


Figure 2: Kaplan-Meier disease-free survival curves by sarcopenia status (sarcopenia includes sarcopenic obesity). Hazard ratio (HR) estimates from multivariable Cox proportional hazards model after adjusting for comorbidity, age and clinical nodal status (cN).

Body composition	Major morbidity or death (n=77)
Normal SMI	4/30 (13.3%)
Sarcopenia	7/39 (18.0%)
Sarcopenic obesity	3/8 (37.5%)

Sarcopenic obesity OR 3.74
(95% CI: 0.70–19.94; p=0.12)

Proportion of major post-operative morbidity or 90-day mortality following lung cancer resection stratified by body composition phenotype. OR from logistic regression analysis compared to normal SMI. Major morbidity defined by Ottawa Thoracic Morbidity and Mortality Scale² ≥3. OR, odds ratio (unadjusted); SMI, skeletal muscle index.

