

EP07.28: Treatment Preferences for Stage II NSCLC in Korea : A Nationwide Survey on Upfront Surgery Versus Neoadjuvant Therapy

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INTRODUCTION

- Use of neoadjuvant chemoimmunotherapy is increasing in clinical stage II and III NSCLC. In stage II specifically, however, real-world treatment choices are still mixed.
- Neoadjuvant chemoimmunotherapy improved event-free survival in CheckMate 816 [1] and KEYNOTE-671 [2]. However, these trials enrolled mostly stage III patients, so **direct evidence for stage II is limited**.
- Stage II is also heterogeneous. It ranges from node-negative T2b/T3 to N1, and the 9th edition TNM [3,4] added cT1N2a, which was previously stage IIIA.
- In Korea, EGFR and ALK alterations are common, and immunotherapy is not indicated for driver-positive disease [6].
- We surveyed Korean thoracic oncology specialists to find out whether the T or the N descriptor drives treatment choice in stage II, and what limits the use of neoadjuvant therapy.

METHODS

Design: Cross-sectional anonymous questionnaire survey through two Korean thoracic oncology societies, KALC and KSTS (December 6, 2025 to January 28, 2026). IRB approved.

Respondents: 124 specialists: 72 thoracic surgeons (58.1%) and 52 medical specialists (39 pulmonology, 12 medical oncology, 1 nuclear medicine).

Scenarios (9th edition TNM): cT2bN0 (IIA), cT3N0 (IIB), cT1N1 (IIA), cT2N1 (IIB), cT1N2a (IIB). For each, respondents chose upfront surgery plus adjuvant therapy or neoadjuvant therapy followed by surgery. Responses were pooled by nodal stratum (N0, N1, N2a), and each respondent was classified as 'Always Upfront', 'Always Neoadjuvant', or Mixed.

Additional items: Further items asked about barriers to neoadjuvant therapy (Q6), criteria for using it (Q7), and willingness to join an RCT (Q8).

Analysis: Cochran–Armitage trend test across nodal strata; McNemar’s exact test for paired N and T contrasts; Fisher’s exact test with Bonferroni correction, used to compare the surgical and medical groups (R 4.3.3). Three respondents answered four scenario questions in free text instead of choosing an option; these answers were excluded, so the number of responses differs slightly across scenarios (cT1N1, cT2N1: n = 123; cT1N2a: n = 122).

DISCUSSION AND CONCLUSION

Actionable Take Away Message

- In the scenarios tested, **the N descriptor, rather than the T descriptor, was the strongest correlate of stated treatment preference** (35.5 to 41.5 vs. 13.0 to 16.1 points; all $p < 0.001$). This ordering was stable in sensitivity analyses.
- The 80.3% neoadjuvant preference for cT1N2a probably reflects its previous stage IIIA label, reclassified only 11 months before the survey. It should be read as **a real-time baseline of the transition period**, not a settled stage IIB preference.
- Treatment preferences were not significantly different between surgical and medical specialists; no medical oncologist chose upfront surgery in every scenario, and surgeons made up half of the Always Neoadjuvant group.

Future Direction for Research

- The main barrier, lack of direct evidence (59.7%), is **itself a reason to conduct a trial**; cost (39.5%) also needs to be addressed in trial design.
- A future stage II trial stratified by the N descriptor (e.g., PROSPECT-LUNG [5]) **appears feasible** to elucidate the adequate treatment; **66.9% of respondents were willing to participate**.

REFERENCES & ACKNOWLEDGEMENTS

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RESULTS

- Upfront surgery was chosen by 84.7% for cT2bN0, 68.5% for cT3N0, 56.1% for cT1N1, 43.1% for cT2N1, and 19.7% for cT1N2a. Grouped by N descriptor, **preference for upfront surgery fell from 76.6% (N0) to 49.6% (N1) and 19.7% (N2a)** (Cochran–Armitage $z = 10.53$, $p < 0.001$) (Fig. 1).
- When only the N descriptor changed between paired scenarios, preference for upfront surgery fell by **35.5 to 41.5 points**; when only the T descriptor changed, by **13.0 to 16.1 points** (95% CIs non-overlapping; all McNemar $p < 0.001$) (Fig. 2).
- Specialty groups did not differ significantly on treatment choice (all adjusted $p \geq 0.337$). 16.9% always chose upfront surgery, 11.3% always neoadjuvant therapy, and **71.8% adapted their choice to each stage II scenario** (Fig. 3).
- The most common barriers to neoadjuvant therapy were **lack of direct evidence (59.7%)** and cost (39.5%; cited more by medical specialists, $p = 0.025$) (Fig. 4). The leading criterion for neoadjuvant therapy was **N2a involvement (68.5%)** (Fig. 5), and **66.9%** were willing to join a future randomized trial (Q8).

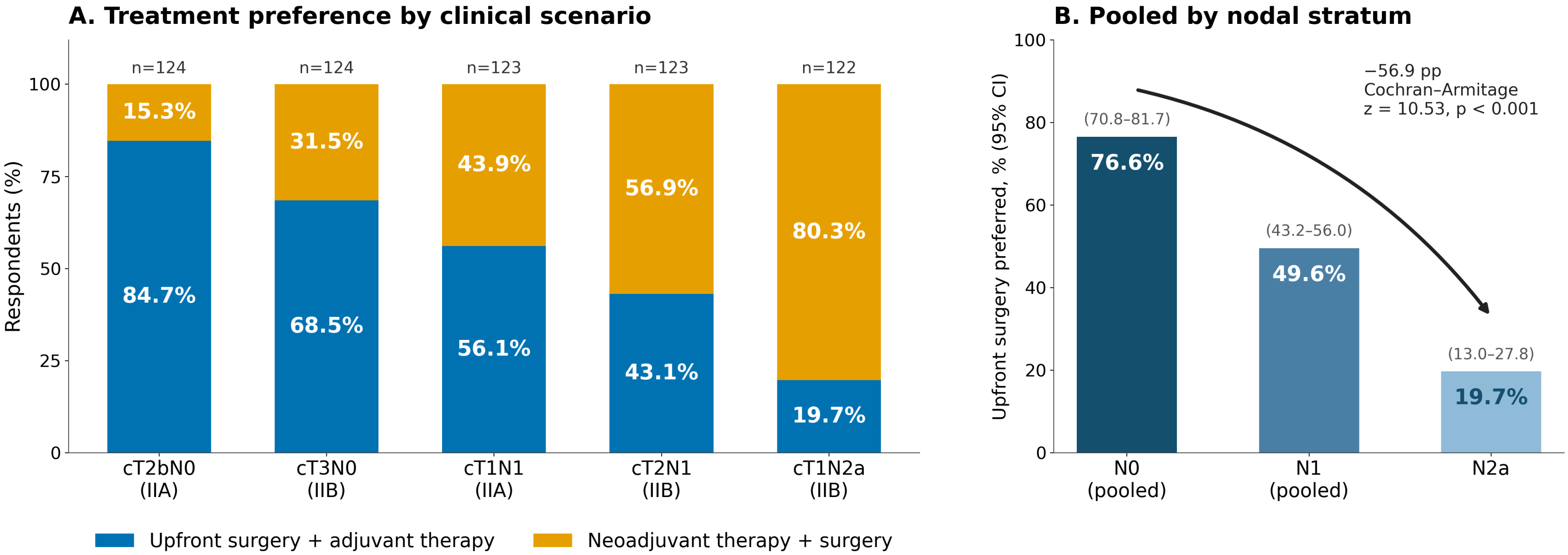


Fig. 1. Treatment preference by clinical scenario (A) and pooled by nodal stratum (B). Blue, upfront surgery; amber, neoadjuvant therapy.

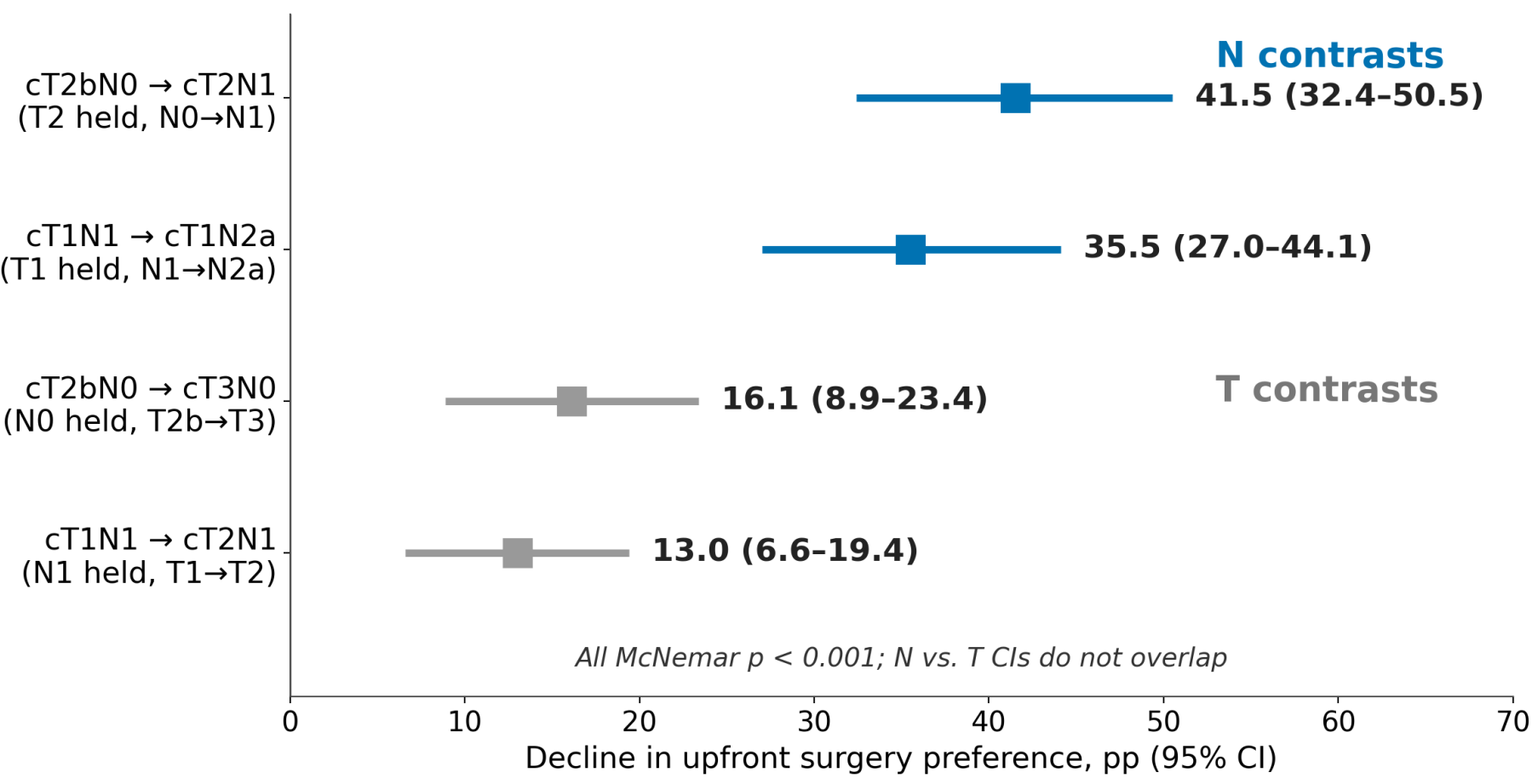


Fig. 2. Paired contrasts: decline in upfront preference, N (blue) vs. T descriptor (gray).

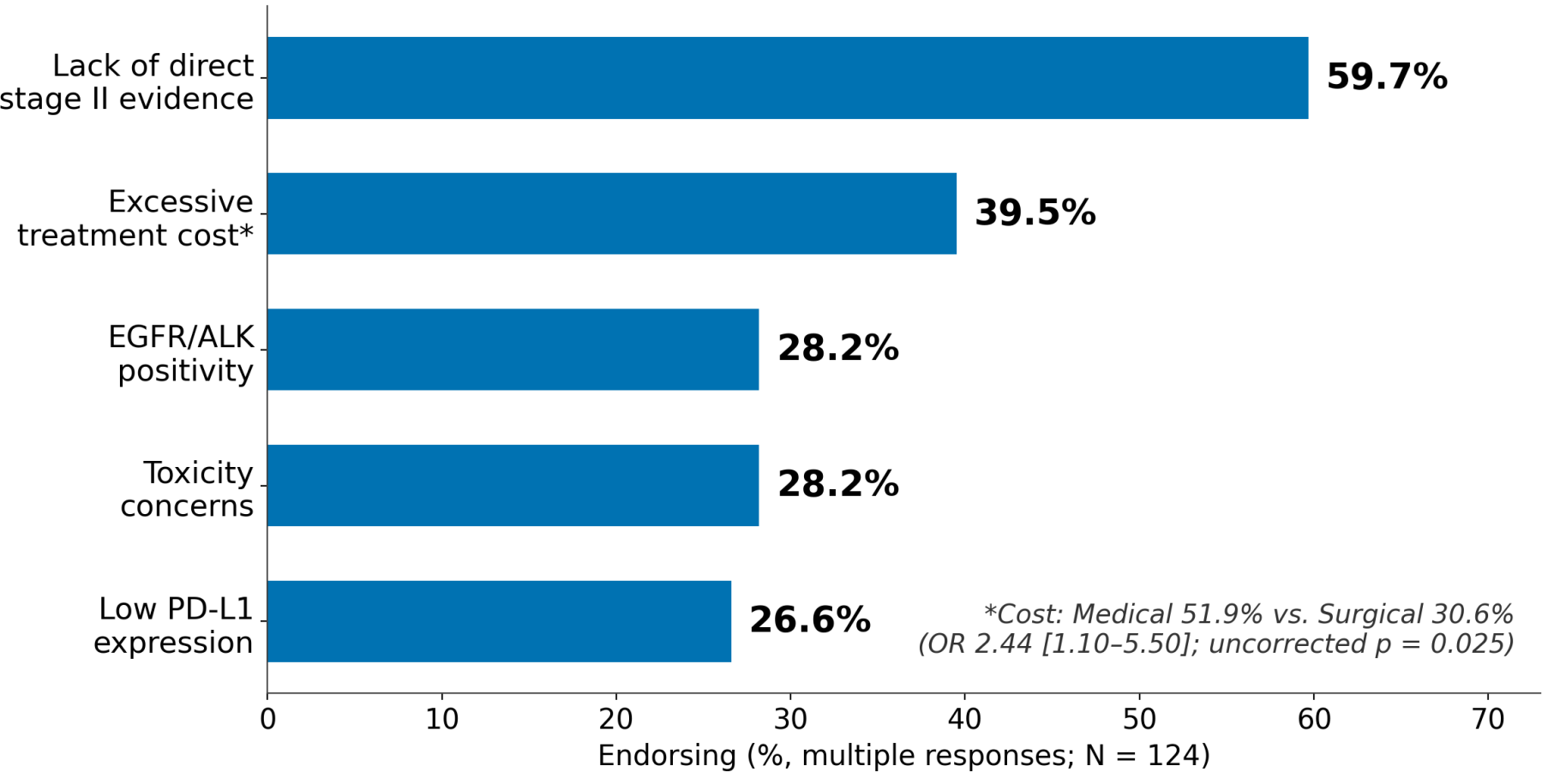


Fig. 4. Barriers to neoadjuvant therapy (Q6; multiple responses).

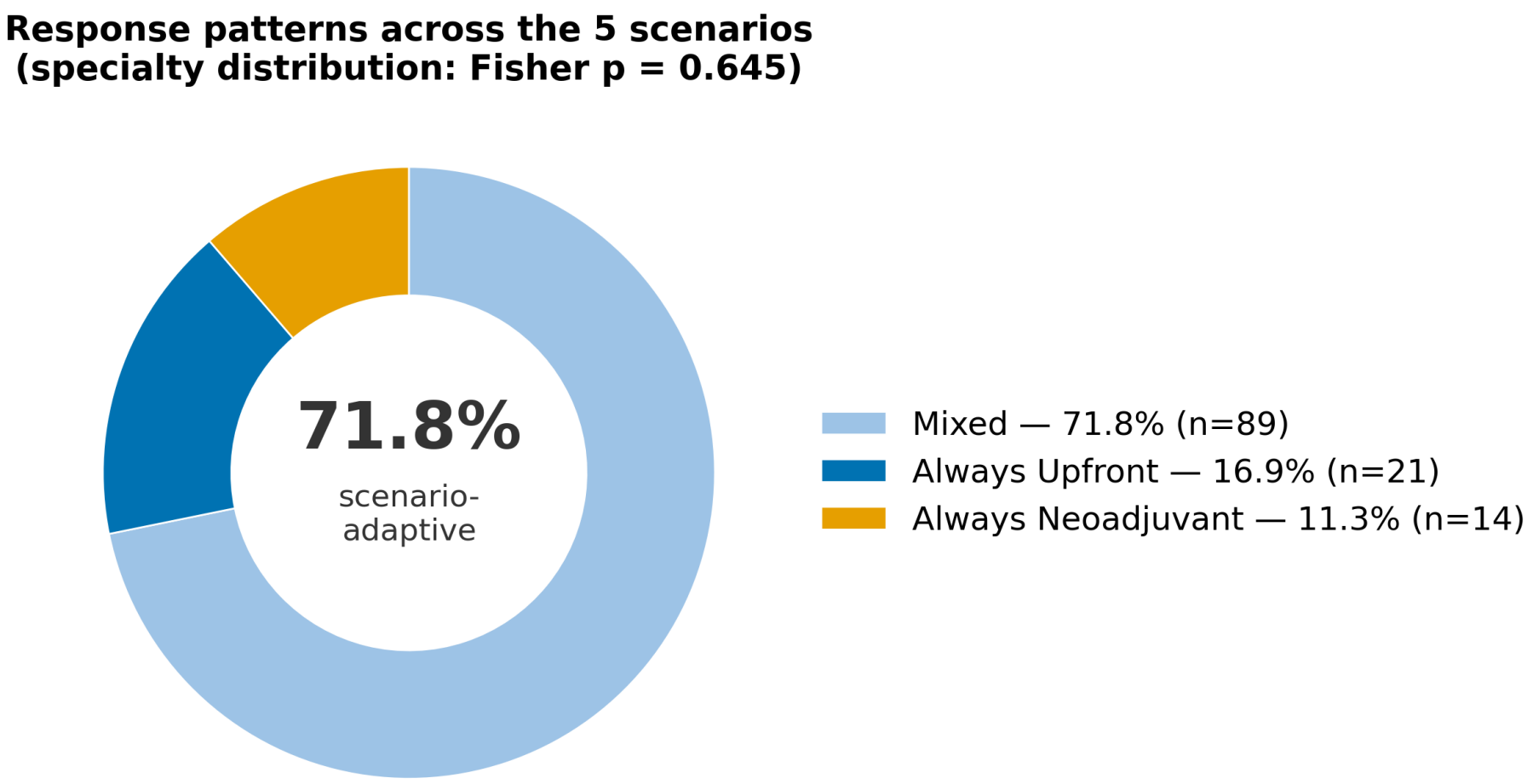


Fig. 3. Response patterns across the five scenarios. No medical oncologist was in the Always Upfront group.

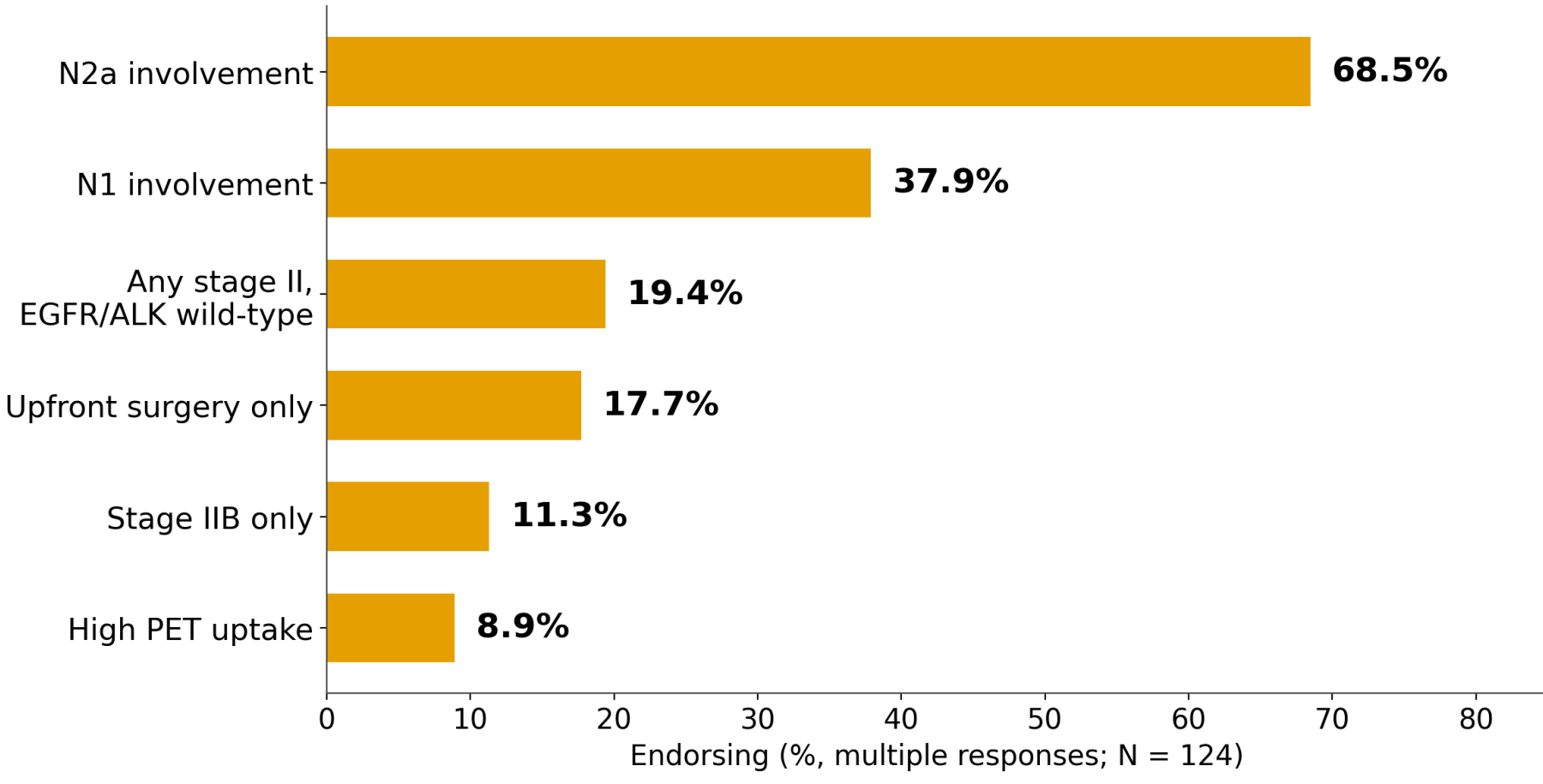


Fig. 5. Criteria for selecting neoadjuvant therapy (Q7; multiple responses).

66.9% of respondents were willing to join a stage II RCT of upfront surgery vs. neoadjuvant therapy (Q8; 95% CI, 57.9–75.1).