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Editorial

# Lung Cancer Research and Study

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## EDITORAL

Lung cancer occurs when cells divide in the lungs uncontrollably. This causes tumors to grow. These can reduce a person's ability to breathe and spread to other parts of the body. Lung cancer is the third most common trusted Source cancer and the main cause of cancer-related death in the United States. It is most common in males, and in the U.S., Black males are around 15% more likely to develop it than white males.

Smoking is a major risk factor, though not everyone who develops lung cancer has a history of smoking. Lung cancer can be fatal, but effective diagnoses and treatments are improving the outlook. This article will explain what lung cancer is, how to recognize the symptoms, and the treatment options available.

Normal cells in the body usually die at a certain stage in their life cycle, thereby preventing a buildup of too many cells. In cancer, however, the cells continue to grow and multiply. As a result, tumors develop. The two main types of lung cancer are small cell lung cancer and non-small cell lung cancer, depending on how they appear under a microscope. Non-small cell lung cancer is more common than small cell lung cancer. Anyone can develop lung cancer, but cigarette smoking and having exposure to smoke, inhaled chemicals, or other toxins can increase the risk.

Reduced tobacco consumption in the U.S. has been associated with a progressive decrease in lung cancer deaths that started around 1990 in men and around 2000 in women. Until now, however, we have not known whether newer treatments might contribute to some of the recent improvement. The researchers found that, in recent years, deaths from NSCLC decreased even faster than the decrease in NSCLC incidence and the decrease in deaths was associated with a substantial improvement in survival.

The primary objective was to examine OS. Secondary objectives were to evaluate the duration of therapy (DoT) and real-world time to progression (rwTTP) while on treatment. The index date was defined as the date of 1L treatment initiation, and patients were followed up until the last date of follow-up or end of study, whichever occurred first.

Baseline patient and clinical characteristics were analyzed using descriptive statistics. OS, DoT, and rwTTP while on treatment were estimated using Kaplan-Meier methods. OS was defined as the time from index date until death.

Patients who were alive at the end of study date were censored using the date last observed in the data. Disease progression was defined as a distinct episode in which the treating physician concluded there had been growth or worsening in disease, as determined by clinic visit notes.

Patients were considered to have discontinued treatment at their last administration/order date upon death, initiation of subsequent therapy, or having a gap of ≥120 days between the last administration date and last known activity date; in the absence of these events, patients were censored at their last administration/order date rwTTP while on 1L treatment was defined as the time from index date until disease progression. Patients without an event were censored at the date of the last clinical note from the progression data or at time of initiation of second-line treatment, whichever occurred first.

All analyses were conducted separately for the I-O plus chemotherapy and I-O monotherapy treatment groups by histology. No statistical analyses for between-group comparisons were undertaken. This real-world study presents one of the largest and most comprehensive analyses to date evaluating outcomes with 1L I-O plus chemotherapy

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