Lung cancers are broadly classified as small-cell carcinomas and non-small-cell carcinomas. Non-small-cell lung cancer is more common and it accounts for up to 75% of lung cancers. Determination of the development of cancer to lungs is solely dependent on mutation of cells leading to the expression of tumor specific proteins. Hence a clear understanding of the vital structural design and physiology of the lungs assists in determination of the stages of this disease. The anatomical architecture of the lungs and their organization with adjacent organs throws light on the site of origin of malignancy, its spreading pattern and clinical presentation etc. This article has summarized the types of lung cancer, pathophysiology along with the microenvironment. The article includes the discussion on the treatment interventions such as surgery, chemotherapy, radiation therapy, the promising potential of immunotherapies and target-oriented therapies in NSCLC. Even though, the lung cancer is escapable however, it is usually diagnosed at an incurable stage.

**Keywords:** lung cancer; Non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC); Target Therapies; Immuno checkpoints; Tumor Microenvironment; Oncogene.

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**Highlights:**

**Objective:** In this review article, our main focus was on the pathophysiology and the various treatments of lung cancer.

- Lung cancer is one of the most fatal chronic respiratory diseases, accounting for more than one million cases were diagnosed annually.
- Treatment of lung cancer severs as a big challenge for an oncologist. SCLC (small cell lung cancer) and NSCLC (non-small cell lung cancer) are two types of lung cancer.
- There are various conventional strategies to treat lung cancer at specific stages of lung cancer. These are either used as along or in combination with other chemotherapeutic agents.
- Chemotherapy is still an effective solution for the treatment, especially in NSCLC. Development of molecular targeted therapy; immunotherapy and immune-checkpoints inhibitors are one of the promising therapies options in both NSCLC and SCLC.

**Introduction**

Carcinomas that originate from respiratory epithelium dominantly in bronchi, bronchioles and alveoli are referred to as lung cancer. This type of cancer is mostly diagnosed at later stages hence leading to high mortality rate. Based on the sizes and appearance of cancerous cells cancer has been classified into two type’s i.e. non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC). According to WHO, lung cancer is the leading cause of mortality across world approximately 18.4 million deaths cases were reported in International agency for research on cancer (IARC global agency observatory) in September, 2018. Lung cancer is also known as bronchogenic carcinoma which affects both females and males. The primary function of the lungs is the exchange of gases between air and blood. It exactly occurs in epithelial cells [1]. There are two main factors which are responsible for causing lung cancer such as external agents including exposure to asbestos, arsenic, chromic, nickel, smoking (over 60 known carcinogens, including radioisotopes, nitrosamine, benzopyrene, etc.), tobacco, air pollution (particulate matter 2.5) [diesel funnels particle with PAH (polycyclic aromatic hydrocarbons)], radon gas (breakdown of radium and decay product of uranium, cause genetic mutation) whereas gene mutation, genetic and epigenetic mutations come under internal factors. These agents are responsible for initiation, progression and malignancy of cancer [2-3]. Different stages of NSCLC and SCLC shown in figure 1. Table 1 summarizes the types of lung cancer according to WHO, 2015.
Fig-1: Stages of lung cancer is depicted in figure (a) NSCLC and (b) SCLC

Table-1: Latest classification of lung cancer proposed by World Health Organization 2015

<table>
<thead>
<tr>
<th>Histological type</th>
<th>Subtype</th>
<th>Immunohistochemical changes</th>
<th>Sub-classification of subtype</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epithelial tumors</td>
<td>Adenocarcinoma</td>
<td>Mostly occurring in 60% of NSCLC. Features: Originates in peripheral lung tissue with central fibrosis and pleural puckering. Pneumocyte marker: TTF-1 and/or Napsin A. Main cause: Nonsmokers, ex-smokers, smokers, and modest smoking history.</td>
<td>Lepidic adenocarcinoma&lt;br&gt;Acinar adenocarcinoma&lt;br&gt;Papillary adenocarcinoma&lt;br&gt;Microcystic adenocarcinoma&lt;br&gt;Solid adenocarcinoma&lt;br&gt;Invasive mucinous adenocarcinoma a) Mixed invasive mucinous adenocarcinoma b) Non mucinous adenocarcinoma&lt;br&gt;Colloid adenocarcinoma&lt;br&gt;Fetal adenocarcinoma&lt;br&gt;Enteric adenocarcinoma&lt;br&gt;Minimally invasive adenocarcinoma a) Mucinous adenocarcinoma&lt;br&gt;Non mucinous adenocarcinoma</td>
<td>[4-5]</td>
</tr>
<tr>
<td>Neuroendocrine tumors</td>
<td></td>
<td>Mostly occurring in 20-30% of lung cancer. Features: Epitomized by tumor proliferation rate, tumor aggressiveness and prognosis and cells having organoid growth pattern, finely granular or “salt-and-pepper” chromatin pattern, and several hallmark neuroendocrine markers. Neuroendocrine markers: Chromogranin A, synaptophysin, and CD56</td>
<td>Small cell carcinoma (Combined small cell carcinoma)&lt;br&gt;Large cell neuroendocrine carcinoma (Combined large cell neuroendocrine carcinoma)&lt;br&gt;Carcinoid tumors a) Typical carcinoid tumor b) Atypical carcinoid tumor&lt;br&gt;Preinvasive lesion Diffuse idiopathic pulmonary Neuroendocrine cell hyperplasia</td>
<td>[4-5]</td>
</tr>
<tr>
<td>Tumor Type</td>
<td>Description</td>
<td>Markers</td>
<td>Origin</td>
<td>Genotype</td>
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<td>----------------------------------</td>
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</tr>
<tr>
<td>Large cell carcinoma</td>
<td>Mostly occurring in 15% of NSCLC. Effective area- originates in a peripheral region with bulky and necrotic appearance. Have heterogeneous group of tumors with adenocarcinoma. Squamous cell differentiation, or a null immunophenotype and genotype.</td>
<td>*</td>
<td>*</td>
<td>[4-5]</td>
</tr>
<tr>
<td>Adenosquamous carcinoma</td>
<td>Rare type of NSCLC, less than 5% of lung cancer. Hybrid type of carcinoma of adenocarcinoma and squamous cell carcinoma.</td>
<td>*</td>
<td>*</td>
<td>[4-5]</td>
</tr>
<tr>
<td>Sarcomatoid carcinomas</td>
<td>Rare type of NSCLC, less than 3% of lung cancer. Features: Spindle and/or giant cell differentiation. Epithelial markers: Pancytokeratin, cytokeratin AE1/AE3, CK7, and EMA.</td>
<td>Pleomorphic carcinoma</td>
<td>Spindle cell carcinoma</td>
<td>[4-5]</td>
</tr>
<tr>
<td>Other and Unclassified carcinomas</td>
<td>Rare type of NSCLC, less than 10% of lung cancer. Features: Rarely arise from bronchial glands.</td>
<td>Lymphoepithelioma-like carcinoma</td>
<td>NUT carcinoma</td>
<td>[4-5]</td>
</tr>
<tr>
<td>Salivary gland-type tumors</td>
<td>Less than 1% of lung cancer. Features: Arise from submucosal glands of the tracheo-bronchial tree, rare intrathoracic malignant neoplasm.</td>
<td>Mucoepidermoid carcinoma</td>
<td>Adenoid cystic carcinoma</td>
<td>[4-6]</td>
</tr>
<tr>
<td>Papillomas</td>
<td>Mostly occurring in less than 1% of lung cancer. Features: Proximal or peripheral (fibrovascular core covered by an epithelium), polyoid, tan-white and friable lesions are prone to into airways lumens. Cause: Smoking.</td>
<td>Squamous cell papilloma</td>
<td>(Exophytic and Inverted) Glandular papilloma</td>
<td>[4-7]</td>
</tr>
<tr>
<td>Adenomas</td>
<td>Less than 1% of lung cancer. Features: Originate in the mucus glands and ducts of the lung airways (bronchi) or windpipe (trachea), and in the salivary glands.</td>
<td>Sclerosing pneumocytoma</td>
<td>Alveolar adenoma</td>
<td>[4-6]</td>
</tr>
<tr>
<td>Other mesenchymal tumors and tumor-like lesions</td>
<td>Rarely occurring tumor Features: Similar genomic features with sarcomas and proliferation of cells. Markers: Cytokeratin, α-SMA, calponin, p63, and S100.</td>
<td>Myoepithelial tumor/myoepithelial carcinoma Pulmonary hamartoma</td>
<td>Granular cell tumor</td>
<td></td>
</tr>
</tbody>
</table>
### Metastatic mesenchymal tumors (pediatric tumors)

**Features:** Solid masses, various types of metastatic tumors (e.g., leiomyosarcoma, synovial sarcoma, low-grade endometrial stromal sarcoma, and undifferentiated uterine sarcoma) occasionally appear as cystic lesions

**Nodular pulmonary amyloidosis IgG-4 related disease**

**Congenital peribronchial myofibroblastic tumor**

**Pleuropulmonary blastoma**

### Lymphohistiocytic tumors

**Lymphohistiocytic tumors**

Extranodal marginal zone lymphomas of mucosa-associated

Less than 1% of all lymphomas.

**Features:** arises from peripheral small bronchi or alveolar epithelial cells

**Markers:** B cell markers (CD19, CD20, CD22, CD79a) complement receptors (CD21 and CD35), and are usually negative for CD5, CD10, and CD23

**Nodular pulmonary amyloidosis IgG-4 related disease**

**Metastatic mesenchymal tumors (pediatric tumors)**

Extranodal marginal zone lymphomas of mucosa-associated

**Features:** Solid masses, various types of metastatic tumors (e.g., leiomyosarcoma, synovial sarcoma, low-grade endometrial stromal sarcoma, and undifferentiated uterine sarcoma) occasionally appear as cystic lesions

**Nodular pulmonary amyloidosis IgG-4 related disease**

**Congenital peribronchial myofibroblastic tumor**

**Pleuropulmonary blastoma**

### Diffuse large cell lymphoma

11–19% of primary pulmonary lymphomas.

**Feature:** Lymphomas chronic inflammation of the marginal zone B cells of the “bronchial-associated lymphoid tissue”

**Markers:** CD20, CD43, Bcl-2, Bcl-6, and MUM-1 (focally) and negative for CD10 and Cyclin D1

### Lymphomatoid granulomatosis

0.5–1% of primary pulmonary lymphomas.

**Feature:** B-lymphoproliferative disorder (B cells and T cells)

**Markers:** CD20, CD3, CD68, ALK1, CD30, CD15, EBV

### Intravascular large B cell lymphoma

Rarely occurring tumors.

**Features:** Occlusive proliferation in vessels (capillaries, small arteries and veins)

**Markers:** C-reactive protein (CRP), LDH, β2-MG, interleukin-2R (IL-2R) or serum albumin

### Pulmonary Langerhans cell histiocytosis

Rarely occurring tumors.

**Features:** Damaging of distal bronchioles and infiltrating of Langerhans’ cell within the lung parenchyma

**Markers:** specific marker langerin (CD207)

### Erdheim–Chester disease

Less than 1% of lung cancer

**Features:** Infiltration of lipid-laden histiocytes with foamy or eosinophilic cytoplasm

**Markers:** Positive and negative stain for CD68 and CD1a respectively

### Tumors of ectopic origin

Germ cell tumors

Intrapulmonary thymoma

Melanoma

Meningioma, NOS

4.5% of patients with SCLC (Uncommon type of tumors).

**Features:** Proliferation of spindle cells, pseudoglands, cystic lesion

**Markers:** Epithelial cells AE1/AE3 or EMA, T cell phenotypes , CD20-positive B cells

### Pathophysiology of Lung Cancer

All cells in the body consist of genetic material called deoxyribonucleic acid (DNA). At the time of maturity cell divides into two new cells and its DNA is exactly duplicated. The normal aging process or environmental factors sometimes lead to DNA mutation (somatic cells mutation) [4-5]. It further leads to activation of promoting oncogenes due to imbalance in hormones or chronic inflammation and inactivation of tumor suppressor genes. These two factors are responsible for alteration in genes and produce abnormal structural proteins which cause tumor. Pathophysiology of lung cancer with their some diagnostic tests and treatment are described in figure 2 whereas, its clinical symptoms are depicted in figure 3.
Fig-2: Pathophysiology of lung cancer along with diagnosis tests and suggested treatment

Fig-3: Clinical symptoms of lung cancer
Microenvironment of Lung Tumor

The concept of lung immune microenvironment is in existence since the “seed-soil” theory of Stephen Paget’s tumor-specific tumor metastasis in 1889. The understanding of microenvironment of lung cancer is very important to further understand how the affected cells can overcome the check point blockade. The tumor microenvironment (TME) is heterogeneous in composition and comprises of cellular components like endothelial cells, as well as its precursor cells, pericytes, myeloid-derived suppressor cells (MDSC), tumor-associated fibroblast (CAF), tumor-associated macrophages (TAM), T cells and B Cells, NK (natural killer) cells, DCs (dendritic cells), growth factors, proteases, and extracellular matrix [16]. The interactions between genetically altered tumor cells and genetically stable intratumoral stromal cells lead to either activated or reprogrammed stroma that may further promote carcinogenesis by contributing to inflammation, immune suppression, therapeutic resistance, or generating premetastatic niches that support the initiation and establishment of distant metastasis. It also affects the activation and metabolism of T cells through various mechanisms. Tumor-infiltrating T lymphocytes have an immune surveillance effect that inhibits the binding to PD-1 and PD-L1, which is positively correlated with resistance, and this resistance develop tumor. Tumor infiltrating T cells can be activated by co-stimulatory receptors (e.g. tumor necrosis factor receptor superfamily members OX40, CD40, 41BB and B7-CD28, and immunoglobulin superfamily member ICOS etc.) and a co-stimulatory receptor in combination with its ligand by enhancing the function of Th1 (T helper type 1) cells or inhibiting the function of Treg (regulatory T cells) cells, killing tumor cells. Its combination with ICB (immune check point blockers) can enhance its anti-tumor efficiency. Treg cells can promote the production of vascular endothelial growth factor (VEGF) in tumor cells and CAF (cancer associated fibroblasts), and reduce IFN-γ and granzyme produced by T cells to reduce immune killing. In tumor patients, Treg cells inhibit specific T cell responses and express greater level of glucocorticoid-induced tumor necrosis factor receptor-associated proteins (GITR) and CTLA-4 [17].

Treatment of Lung Cancer

The basic choice of treatment of a patient depends upon the type of cancer and whether the disease has metastasized to distant organs. Lung cancer can be treated with various methods such as surgery, radiofrequency ablation, immunotherapy, stereotactic ablative, radiation therapy, photodynamic therapy, Radiofrequency ablation (RFA), tyrosine kinase inhibitors (TKI) and targeted specific therapy [3, 18, 19].

Surgery

The surgery is the primary treatment for restricted patients with early-stage cancer and is performed basically for the stage-I NSCLC, stage-II NSCLC and limited-stage SCLC and lymph node tumors may not be benefited from surgery, after which ancillary chemotherapy is given [20]. The surgery involves the removal of the entire lobe in which the tumor is located and a margin of healthy tissue. Agenda for removal of lung cancer includes wedge resection to remove cancerous tissue, segmental resection to remove a major portion of the lung, but not an entire lobe, lobectomy (removal of entire lung lobe), pneumonectomy (removal of entire lung). The objective of surgery is to totally eradicate all the tumor cells and thereby provide a cure [3, 18-19]. Prior surgical techniques such as video-assisted thoracic surgery (VATS) minimal involved invasion and were used to perform a lobectomy or wedge resection, the procedure involves inserting a long thin tube with an attached camera (thoracoscope) connected to a video monitor so that the surgeon can see inside the chest and remove cancerous tissue from the lung [18]. Robot-assisted thoracic surgery (RATS) is another minimally invasive way of treating lung cancer [19].

Chemotherapy

Chemotherapy is the most powerful tool to treat lung cancer, new or existing drugs are used to treat/kill cancerous cells [20]. These drugs, may be targeted to cancerous cells (less damage to normal cells) and involve immunotherapy (use the own body’s immune system to destroy cancer cells). It is used in all stages of cancer [21]. Chemotherapy works in three different ways such as neoadjuvant or primary systemic lung cancer chemotherapy (before surgery to destroy or remove cancerous cells) [18, 22], adjuvant chemotherapy (to prevent cancer spreading throughout) [18, 23] and Lastly large circulation of chemotherapeutic drugs [18, 24].Cisplatin was approved by the FDA in 1978 and is the most successful drug discovery against cancer still and is widely used in combination with other chemotherapeutic agents. To overcome various side effects like nephrotoxicity, neurotoxicity, retinotoxicity, and ototoxicity, cisplatin derivatives are used [19, 25]. Chemotherapeutic agents which are commonly used to treat lung cancer are carboplatin (Paraplatin or Paraplatin), cisplatin (Platinol-AQ or Platinol), docetaxel (Taxotere), etoposide (Toposar or VePesid), gemcitabine hydrochloride (Gemzar) with cisplatin (Platinol-AQ or Platinol), paclitaxel (Taxol) in combination with cisplatin (Platinol-AQ or Platinol), paclitaxel albumin-stabilized nanoparticle formulation (Abraxane also called albumin-bound paclitaxel or nabpaclitaxel) in combination with carboplatin pemetrexed disodium (Alimta), topotecan hydrochloride (Hycamtin), and vinorelbine tartrate (Navelbine) [26]. US- FDA approved
chemotherapeutic drugs for lung cancers are summarized in table 2.

Table-2: USFDA approved chemotherapeutic drugs for lung cancer

<table>
<thead>
<tr>
<th>Drug Name/ Brand</th>
<th>Stages</th>
<th>Formulation</th>
<th>Dose</th>
<th>FDA Approval</th>
<th>Patent expiry(US)</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANGIOGENESIS INHIBITOR/VEGF RECEPTOR INHIBITOR</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Bevacizumab (Avastin)</td>
<td>Non-squamous NSCLC at stage IV</td>
<td>Solution for IV infusion after dilution</td>
<td>100 mg, 400 mg</td>
<td>February, 2004</td>
<td>July, 2019</td>
<td>[27]</td>
</tr>
<tr>
<td>Ramucirumab (Cyramza)</td>
<td>2nd line of treatment metastatic NSCLC at stage IV and hepatocellular carcinoma with elevated alpha-fetoprotein</td>
<td>Solution for IV infusion after dilution</td>
<td>10 mg/ml</td>
<td>December, 2014</td>
<td>November, 2031</td>
<td>[28]</td>
</tr>
<tr>
<td><strong>ANTIMETABOLITES</strong></td>
<td></td>
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</tr>
<tr>
<td>Gemcitabine (Gemzar)</td>
<td>NSCLC at stage IIIA, IIIB, IV and SCLC (adenocarcinoma &amp; squamous cell carcinoma)</td>
<td>Powder for IV infusion after reconstitution,</td>
<td>200 mg or 1mg</td>
<td>August, 1998</td>
<td>May, 2013</td>
<td>[29]</td>
</tr>
<tr>
<td>Infugem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methotrexate</td>
<td>Squamous cell and small cell lung cancer</td>
<td>Solution for IV infusion, powder for IV, IM, intra-arterial, or Intrathecal administration after dilution</td>
<td>25 mg/ml</td>
<td>April, 2005</td>
<td>January, 2026</td>
<td>[24]</td>
</tr>
<tr>
<td>(Trexall)</td>
<td></td>
<td>scored tablets</td>
<td>1g, 5mg, 7.5mg, 10mg, 15mg</td>
<td>March, 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pemetrexed (Alimta)</td>
<td>first-line treatment of non-squamous-cell lung cancer, second-line treatment of NSCLC at stage IV</td>
<td>Powder for IV infusion after reconstitution and dilution,</td>
<td>100mg, 500mg</td>
<td>August, 2004</td>
<td>May, 2022</td>
<td>[30]</td>
</tr>
<tr>
<td><strong>ANTIMICROTUBULE AGENTS</strong></td>
<td></td>
<td></td>
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<tr>
<td>Docetaxel (Taxotere)</td>
<td>Advance and metastatic NSCLC at stage IIIA, IIIB, IV</td>
<td>Solution for IV infusion after dilution</td>
<td>40 mg/ml</td>
<td>December, 1999</td>
<td>May, 2014</td>
<td>[31-32]</td>
</tr>
<tr>
<td>Pachtaxel (Taxol)</td>
<td>Squamous NSCLC at stage IV</td>
<td>Solution for IV infusion after dilution</td>
<td>6 mg/ml</td>
<td>October, 2012</td>
<td>February, 2026</td>
<td>[32-33]</td>
</tr>
<tr>
<td>Pachtaxel (Abraxane)-bound to albumin</td>
<td>NSCLC</td>
<td>Powder for IV infusion after reconstitution-on, first-line treatment of locally advanced or metastatic non-small cell lung cancer, in combination with carboplatin</td>
<td>100 mg/ vial</td>
<td>October, 2012</td>
<td>December, 2023</td>
<td>[34]</td>
</tr>
<tr>
<td>Vinorelbine (Navelbine)</td>
<td>NSCLC at stage III,</td>
<td>Solution for IV injection after dilution</td>
<td>10 mg/ml</td>
<td>December, 1994</td>
<td>February, 2003</td>
<td>[35]</td>
</tr>
<tr>
<td><strong>HUMAN EGFR INHIBITOR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Necitumumab (Portrazza)</td>
<td>Metastatic squamous NSCLC</td>
<td>solution for IV infusion after dilution</td>
<td>800 mg/ 50 ml</td>
<td>November, 2015</td>
<td>2025</td>
<td>[36]</td>
</tr>
<tr>
<td><strong>Kinase inhibitors</strong></td>
<td></td>
<td></td>
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<tr>
<td>Afatinib (Gilotrif)</td>
<td>Metastatic squamous NSCLC with EGFR mutation at stage IV</td>
<td>Tablets</td>
<td>20 mg, 30 mg, 40 mg</td>
<td>July, 2013</td>
<td>October, 2029</td>
<td>[37]</td>
</tr>
<tr>
<td>Alectinib (Alecensa)</td>
<td>ALK+ and Metastatic squamous NSCLC</td>
<td>Capsules</td>
<td>150 mg</td>
<td>December,2015</td>
<td>May, 2031</td>
<td>[38]</td>
</tr>
</tbody>
</table>
Radiotherapy

Radiotherapy is used to deliver high energy X-rays/ionizing radiation i.e. Radium (228Ra), Iridium (192Ir), Phosphorous (32p), and Cobalt (60Co) that destroys DNA of cancer cells or shrink the tumor cells. It is especially used as primary treatment for NSCLC; before surgery it is used to shrink the tumor, after surgery it is used to remove remaining cancer cells in the treated area. It is also in used different cancer treatments that have spreaded to the brain and other parts of the body [58]. A delivery technique in radiotherapy includes external beam technique (EBT), conformal radiation therapy or Intensity-modulated radiation therapy (MRT), and branchtherapy or localized therapy (BLT). EBT is an intervention technique used for lung cancer treatment in which a beam of very few highly focused doses or fractionated radiation therapy is used directly at the site of the tumor [59]. MRT is comparatively new technique that uses 3D image of tumor cell CT scanner; it serves as the target for a high dose radiation beam. BLT is an after surgery procedure in which radiation is directly delivered at the site of obstruction through the plastic tube which is temporarily inserted into the airway [60].

Radiotherapy and Microwave Ablation (MWA) of Lung Tumor

Radiofrequency ablation (RFA) for lung tumors was first introduced in 2000 by Dupuy et al. [61]. It is an invasive treatment that uses image guidance technique to insert a needle containing multiple electrodes through the skin into the specific site of the tumor. Due to high frequency sinusoidal
(electrical) currents are passed through the electrode to ground pads (placed on the body) which create focal heat that destroys the cancer cells surrounding the electrode (thermal destruction of cells and coagulation necrosis). MWA is the minimally invasive treatment that uses microwaves heat which destroys the tumor and also used for the guidance of needle placement in the tumor. MWA is used for the treatment of lung cancer whereas radiofrequency ablation may be limited by the accelerated lung’s low electrical conductivity and poor thermal conduction [19].

**Stereotactic Ablative Body Radiotherapy (SABRT)**

SABRT is an advancement of an external beam of radiation therapy; high dose radiation is directly delivered to extracranial target within the body either as single dose or as a small fraction [62]. This technique of treatment is widely used for inoperable stage I NSCLC and it improves local control or prolongs overall survival without an increase in major toxicity as compared to standard radiotherapy. Radiotherapy represents a safer and potentially curative option for stage I NSCLC in many patients who have smoking-related cardiac or respiratory comorbidities that make them unfit for operation [63].

**Supportive and Palliative Care (SPC)**

SPC also plays a vital role in the management of lung cancer that improves the quality of lung cancer patients. Temel and co researchers studied and analyzed the effect of early specialised palliative care support as compared to standard care in ambulatory patients with metastatic NSCLC referred to the medical oncology outpatient department [64] and found a significant difference in patient survival [65]. SPC includes medication to manage dyspnoea in patients with lung cancer, which includes use of systemic opioids (dose 10 to 30 mg/ml) [66, 67], sustained release morphine [68], frusemide nebulised (dose of 40 mg/4 ml) to support chronic refractory breathlessness [69, 70]. It further includes non-pharmacological management of dyspnoea in lung cancer to reduce anxiety and distress [71, 72], and interventions to control psychological distress and unmet needs in lung cancer patients nursed in gradually increasing muscle relaxation combined with education on self-management of symptoms at the beginning and middle of radiotherapy [73], coping skills training for care givers also showed improvements in patient- and care giver-reported outcomes, including depression and self-efficacy over time [74]. An overarching specialist approach to palliative care delivery (by Quill and Abernathy and supported within the 2017 ASCO guidelines) introduced different types of potential models which are; concurrent care model that involves interdisciplinary palliative care team and triggered integration model which involves the oncology care team backed by the palliative care team. Concurrent and triggered integration models are hybrid of the models [75].

**Immunotherapy**

Immunotherapy is one of the most preferred treatments for lung cancer especially in the advanced metastatic stage of NSCLC because it can change or even enhance the survival rate of cancer patients. The significance of immune system lies in its potential to protect from attacking normal cells in body. For this purpose the proteins i.e. checkpoints on normal cells are required to be turned on/off to trigger/start the immune response. Two immune checkpoint inhibitor pathways are programmed cell death protein 1 (PD-1)Programmed death-ligand 1 (PD-L1) and cytotoxic T-lymphocyte-associated antigen-4 (CTLA-4). Immunotherapy of cancer works against tumor cells by repairing and enhancing the immune system which controls the killing of the tumor cells. The very first-time immune phenomenon was discovered by Coley et al., 1893 [76-77]. An immunological checkpoint inhibitor severs as an immune blocker that prevents the release of tumors, and also induces the re-activation of T cells for the immune response to the tumor effect, thereby achieving an anti-tumor role as a new weapon against tumors. The prevalent mechanism by which lung cancer cells get away from the host’s immunological response is through the expression of PD-L1, also called B7-H1 or CD274 [78]. PD-1 is an immune-regulatory receptor present on the surface of activated T cells. The PD-1 and PD-L1 interaction inhibits T cell responses leading to apoptosis of tumor-specific T cells and thus promotes differentiation of CD4+ T cells into regulatory T cells, and further avoids tumor cell resistance [79]. Immunotherapy can have a major role in cancer management either as a monotherapy or in the combination of standard treatment. However, the biggest threat is to ensure the maximum durable response with the minimum toxicity. There are three stages of cancer immune editing theory which involves elimination/ immune surveillance, equilibrium, and escape. Tumor cells (less immunogenic) are successfully destroyed by the host’s immunity; this is called the elimination stage and reaches to equilibrium stage. In this stage, the immune system fails to completely abolish all cancer cells, but it can effectively manage further tumor growth. In the escape stage, the tumor outgrowth is out of immune control, as the cancer cells that have escaped continue to reproduce [80]. The cancer cells co-opt specific pathways of the immune system, especially against T cells targeting specific tumor antigens, leading to tumor resistance. However, as numbers of checkpoints are developed by ligand-receptor interactions, they can be easily blocked by antibodies or regulated by engineered ligands or receptors [81]. Two of the most encouraging approaches for blockade of immune checkpoints are through checkpoint inhibitor that includes cytotoxic T-lymphocyte-associated antigen-4 (CTLA-4) and PD1 inhibitors as well as vaccine
therapy [82]. Vaccines involved in immunotherapy are summarized in Table 3.

### Table 3- Summary of immunotherapy vaccines

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Immunological responses</th>
<th>Stages</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIGEN- SPECIFIC VACCINES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mucin 1: A Cell Surface-Associated Antigen (type 1 transmembrane proteins) L-BLP25 (BLP25) Stimuvax, Biomira, Alberta, CA</td>
<td>Extracellular core peptide of MUC1</td>
<td>Stage III NSCLC after treatment</td>
<td>[60,83-85]</td>
</tr>
<tr>
<td>GD3 (cell surface ganglioside antigen) Anti-idiotypic Antibody Bec2Plus, BCG Vaccine</td>
<td>Surface of cell</td>
<td>Phase 3 SCLC after chemotherapy and radiotherapy</td>
<td>[83,86-87]</td>
</tr>
<tr>
<td>Neu-Glycosylated Gangliosides 1E10 Antidiotypic</td>
<td>Cell surface</td>
<td>Phase I SCLC and stage IIB/IV NSCLC</td>
<td>[83,88-89]</td>
</tr>
<tr>
<td>Toll-like Receptor 9 Vaccine PF-3512676</td>
<td>TLR9 is expressed on B and T lymphocytes, plasmacytoid cells, and dendritic cells</td>
<td>Stage IIB/IV NSCLC</td>
<td>[83,90-91]</td>
</tr>
<tr>
<td>Melanoma-Associated Antigen A3 Immunotherapeutic</td>
<td>Tumor-specific antigen that is not expressed on normal cells.</td>
<td>stage IB to II NSCLC</td>
<td>[83,92-93]</td>
</tr>
<tr>
<td>Nine class I peptides (from CEA, p53, HER-2/neu, MAGE-2 and -3) with PADRE</td>
<td>CTL responses</td>
<td>IIB–IV or recurrent</td>
<td>[94]</td>
</tr>
<tr>
<td>Modified Ankara virus containing MUC-1 and IL-2</td>
<td>CTL responses</td>
<td>IIB–IV</td>
<td>[95]</td>
</tr>
<tr>
<td>Optimized class I hTERT peptide p572Y and native peptide p572</td>
<td>CTL responses</td>
<td>III–IV</td>
<td>[96]</td>
</tr>
<tr>
<td>Immature DCs pulsed with apoptotic bodies from NSCLC cell line</td>
<td>CTL responses</td>
<td>I–IIIB</td>
<td>[97]</td>
</tr>
<tr>
<td>Seven ras peptides encompassing predicted mutations of codon 12</td>
<td>DTH responses</td>
<td>I or IV</td>
<td>[98]</td>
</tr>
<tr>
<td>hTERT class I peptide p611 and class II peptide p540 with GM-CSF</td>
<td>T-cell proliferation</td>
<td>IIIB–IV</td>
<td>[99]</td>
</tr>
<tr>
<td>L523S gene immunized in a plasmid followed by a viral vector</td>
<td>Humoral responses</td>
<td>IB–IIIB</td>
<td>[100]</td>
</tr>
<tr>
<td>Autologous tumor cells with K562 cells transfected with GM-CSF</td>
<td>DTH/humoral responses</td>
<td>III–IV</td>
<td>[101]</td>
</tr>
<tr>
<td>Dexosomes pulsed with MAGE-A3, -A4, -A10 and -3DPO4 peptides</td>
<td>DTH responses</td>
<td>III–IV</td>
<td>[102]</td>
</tr>
<tr>
<td>Class I WT1 peptide p235</td>
<td>CTL/DTH responses</td>
<td>IV</td>
<td>[103]</td>
</tr>
<tr>
<td>SART-1, -2 and -3, CypB, Lck, and ART-1 and -4 peptides</td>
<td>CTL/DTH responses</td>
<td>IV or recurrent</td>
<td>[104]</td>
</tr>
<tr>
<td>B7.1 and HLA A1- or A2-transfected allogenic NSCLC cell line</td>
<td>CTL responses</td>
<td>IIB–IV</td>
<td>[105]</td>
</tr>
<tr>
<td><strong>TUMOR CELL VACCINES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Granulocyte-Macrophage Colony-Stimulating Factor-Transduced Allogeneic Cancer Cellular Immunotherapy</td>
<td>APCs to the site of vaccination</td>
<td>Stage I/II NSCLC</td>
<td>[83,106-107]</td>
</tr>
</tbody>
</table>

**Immune Resistance and Checkpoint Inhibition**

CTLA4 (homologous to T cells co-stimulatory protein) is a member of the immunoglobulin family and is expressed by activated T cells, which delivers an inhibitory signal to T cells. The combination of the molecules binds to CD80 and CD86 with greater affinity, they are also known as B7-1 and B7-2, respectively, on antigen-presenting cells [17, 109]. The FDA approved CTLA-4 inhibitors are Ipilimumab (fully humanized IgG1 monoclonal antibody) and Tremelimumab. The antitumor immune response is initiated by the recognition of the tumor antigens by T lymphocytes followed by the co-stimulatory binding of T-cell receptors (TCR) to peptide-major histocompatibility complex (MHC) on antigen presenting cells (APCs). CD28, a stimulatory molecule represented on T cells that promotes T cell activation by binding to CD80 and CD86 (B7-1 and B7-2) ligands on APCs [110]. PD-1 is a member of the extended CD28/CTLA-4 family of T cell, and it is also considered as an immune checkpoint receptor, expressed on activated T cells. Its ligands consist of
PD-L1 and PD-L2, and mainly tumors are expressed by PD-L1 [111]. The combination of PD-1 and PD-L1, delivers the inhibitory signals that regulate reproduction and viability of CD4+ T and CD8+ T cells which have been shown in normal individuals in order to minimize the damage of the immune response to surrounding tissues and to prevent the development of autoimmune diseases [111-112]. In patients, it can reduce T-cell immunity killing the tumor local microenvironment leading to tumor immune escape and the progress of tumor growth [113]. A number of clinical studies [113-115] have demonstrated that PD-1/PD-L1 inhibitors have excellent efficacy in advanced NSCLC. When PD-1 binds to its ligands, PD-L1 and PD-L2 are expressed on APCs (Antigen presenting cells) on some normal and cancer cells and leads to T cell inactivation [116]. PD-L1 can interact with the B7 molecules, resulting in T cells turning off [117]. PD-1-induced inhibition is a possible mechanism for adjusting immune resistance. Thus, anti-PD-1 antibodies can be generated to bind to the PD-1 receptor and blocking its interaction with PD-L1/L2 and thus preventing T cell inactivation [118]. FDA approved drugs for PD-1/PDL-1 are Nivolumab [55] (a full human IgG4 monoclonal antibody against PD-1 and first checkpoint inhibitor), Pembrolizumab [56-57] (human monoclonal antibody against PD-1 and its ligand PD-L1), Atezolizumab [53] (fully humanized, engineered monoclonal antibody of the IgG1 isotype against PD-L1), and Durvalumab [54] (human immunoglobulin G1 kappa (IgG1κ) monoclonal antibody against PD-L1 with PD-1 and CD80). Immune cycle of lung cancer is represented in figure 4. Various checkpoints of lung cancer which are involved in treatment are summarized in Table 4.

**Fig-4: Lung cancer immune cycle**
Anaplastic Lymphoma Tyrosine kinase inhibitors (TRI) are known to inhibit mutation of EGFR and its constitutive activation via reversible inhibition of the ATP-binding pocket in the EGFR kinase domain. The major mechanism behind this resistance is T790M mutation within the EGFR kinase domain. It also increases affinity for ATP, thus reducing inhibitor binding to the EGFR kinase domain while preserving catalytic activity [106].

Table-4: Summary of Immunological checkpoints for treatment of target sites in lung cancer

<table>
<thead>
<tr>
<th>Immunoglobulin Antibiotics</th>
<th>Targeted site</th>
<th>Activated by</th>
<th>Action /Activity</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphocyte activation gene-3 (LAG-3) Third Inhibitory Receptor</td>
<td>CTLA4</td>
<td>T cells</td>
<td>Reduce T_reg activity in-vivo</td>
<td>[17,119]</td>
</tr>
<tr>
<td></td>
<td>PD1-PDL1</td>
<td>NK cells B cells Plasma cells</td>
<td>Anti-tumor activity (advance lung cancer)</td>
<td></td>
</tr>
<tr>
<td>T cells Ig and mucin domain-3 (TIM-3) Inhibitory Activity Of T Cells</td>
<td>CD4+ T helper 1 (Th1)</td>
<td></td>
<td>Peripheral tolerance</td>
<td>[17,120]</td>
</tr>
<tr>
<td></td>
<td>CD8+ T cytotoxic 1 (Tc1) and Th17 cells</td>
<td></td>
<td>Loss of T cells in tumors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CD4+ and CD8+</td>
<td>Galectin -9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CD4+ T cells</td>
<td></td>
<td>Tumor infiltrating lymphocytes in lung cancer patients</td>
<td></td>
</tr>
<tr>
<td>Killer cell immunoglobulin like receptor (KIR) (glycoproteins)</td>
<td>T CD8+ Cells</td>
<td>NK cells</td>
<td>Cytotoxic activity</td>
<td>[17,121]</td>
</tr>
</tbody>
</table>

CTLA4: cytotoxic T-lymphocyte associate protein; PD1: programmed cell death protein; PDL1: programmed death ligand 1; Treg: regulatory T cells; NK cells: natural killer cells.

Targeted Therapies

Target Cells with Anti-Angiogenesis Inhibitor

Anti-angiogenesis therapy is a developing field in lung cancer treatment. Vascular endothelial growth factor (VEGF) is playing a significant role in blocking tumor vascularization or it interferes with the activity of the growth factor receptors and molecular pathways that are triggered by the activation of this receptor. VEGF drugs would cause a reduction in blood vessel sprouting and the formation and moderate destruction of existing tumor vasculature. However, recent studies conclude that anti-angiogenesis drugs lead to normalization of the tumor vasculature (means normal phenotype of tumor cells) and also increase the delivery of oxygen and drugs to the tumor thus lifting the local hypoxia (which leads to selection of more aggressive tumor clones) and amplification of chemotherapeutic efficiency [106].

Target Cells with Epidermal Growth Factor Receptor Inhibitors

Epidermal growth factor receptor (EGFR) is one of the proteins (transmembrane growth factor receptor) which are present on the surface of the cell and it is responsible for the growth, survival, and proliferation of the cell. The huge amount of EGFR is present on the surface of tumor cells which causes unnecessary proliferation of cells. EGFR inhibitors are used to block the signals and growth of tumor cells [77]. It may further lead to shrinkage of tumor cells due to alteration in the EGFR gene and is termed as T790M mutation [107].

Tyrosine kinase inhibitors (TRI) are known to inhibit mutation of EGFR and its constitutive activation via reversible inhibition of the ATP-binding pocket in the EGFR kinase domain. The major mechanism behind this resistance is T790M mutation within the EGFR kinase domain. It also increases affinity for ATP, thus reducing inhibitor binding to the EGFR kinase domain while preserving catalytic activity [108].

Target Cells with ALK (Anaplastic Lymphoma Kinase) Genes

Translocation and functional impairment of the ALK genes is responsible for the mutation, proliferation and survival of lung cancer cells. Generally, it is a chromosomal rearrangement of genes in which EML4-ALK product is formed due to the fusion between EML4 (echinoderm microtubule-associated protein-like 4) and ALK genes. This product is responsible for the constitutive activation of the kinase [38, 40]. Approximately, 3-4% of NSCLC patients have this type of fusion gene product [90]. This rearrangement may produce abnormal ALK protein, which is also responsible for the unwanted growth of cells [122].

Target Cells with Braf (V-Raf Murine Sarcoma Viral Oncogene Homolog B1)

BRAF is a RAF serine/threonine protein kinase. Mutation of BRAF with RAF kinase activates the MAPK pathway, which causes uncontrolled growth and proliferation of the cells. Approximately 2-3% of NSCLC cases are reported to be due to a mutation in BRAF. Valine 900 Glu (V900E) mutation within exons 15 kinase domain contributes to lung cancer (lung adenocarcinoma) [108].

Anti Inflammatory Therapies

It has been observed during clinical trials that long term use of aspirin, which is primarily used to prevent cardiovascular disease, also contributes in reducing the lung cancer death rate [125]. A large randomized trial of canakinumab, an antibody targeting IL-1β in patients with atherosclerosis, showed that patients receiving canakinumab had a statistically significant reduction in new lung cancer incidence and mortality [123]. Two recent studies depicted the future therapeutic potential of the NF-κB-mediated inflammatory pathway in lung cancer. The presence of oncogenic Ras, inflammatory stimuli depicts the cox-1, cox-2 involvement of NF-κB that further augments Ras activity and enzyme IKK2 and Timp1 which activates...
the inflammatory response of the body may effectively treat certain lung cancers [126].

The list of drugs used in targeted therapy along with their FDA status is discussed in Table 5.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Drug type</th>
<th>Effect</th>
<th>Combine with</th>
<th>Clinical trials</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bevacizumab</td>
<td>Monoclonal antibody against VEGF</td>
<td>Improved PFS and RR in patients with non-squamous NSCLC</td>
<td>FDA approval first-line treatment along with platinum-based drugs – carboplatin and paclitaxel</td>
<td>Phase III</td>
<td>[106,123-124]</td>
</tr>
<tr>
<td>Ramucirumab (Cyramza)</td>
<td>Monoclonal antibody against VEGFR</td>
<td>Improved PFS and RR in patients with non-squamous NSCLC</td>
<td>FDA approval second-line treatment along with platinum-based drugs – carboplatin and paclitaxel</td>
<td>Phase IV</td>
<td>[28]</td>
</tr>
<tr>
<td>Aliberecept</td>
<td>Decoy receptor fusion protein, binding VEGF-A, VEGF-B, and Placental growth factor</td>
<td>Improved PFS and RR in patients with NSCLC</td>
<td>Combination with docetaxel</td>
<td>Phase III</td>
<td>[106,124]</td>
</tr>
<tr>
<td>Axitinib</td>
<td>MT-TKI, against VEGFR-1, 2 and 3, PDGFR and c-kit</td>
<td>Promising phase II results in patients with NSCLC</td>
<td>Combination with docetaxel</td>
<td>Phase II</td>
<td>[106]</td>
</tr>
<tr>
<td>Cediranib</td>
<td>MT-TKI, against VEGFR-1, 2 and 3, PDGFR and c-kit</td>
<td>Significant activity and toxicity in patients with NSCLC</td>
<td>Combination with docetaxel</td>
<td>Phase III advance NSCLC</td>
<td>[106,123-124]</td>
</tr>
<tr>
<td>Motesanib</td>
<td>MT-TKI, against VEGFR-1, 2 and 3, PDGFR, c-kit and RET</td>
<td>Improved PFS in a phase II trial in the setting of NSCLC</td>
<td>Combination with carboplatin and paclitaxel</td>
<td>Phase III</td>
<td>[106,123-124]</td>
</tr>
<tr>
<td>Sorafenib</td>
<td>MT-TKI, against VEGFR-2 and 3, PDGFR, B-Raf and C-Raf</td>
<td>Increased PFS in patients with NSCLC</td>
<td>PFS and OS negative when giving in combination with chemotherapy Pending</td>
<td>Phase III</td>
<td>[106,123-124]</td>
</tr>
<tr>
<td>Sunitinib</td>
<td>MT-TKI, against VEGFRs, PDGFR, c-kit, fli3, RET and CSF-1R</td>
<td>Increased PFS and RR</td>
<td>combination with erlotinib, in patients with NSCLC</td>
<td>Phase III</td>
<td>[106,124]</td>
</tr>
<tr>
<td>Endostatin</td>
<td>Natural inhibitor of angiogenesis</td>
<td>Increased PFS and RR</td>
<td>combination with chemotherapy and chemoradiation in NSCLC</td>
<td>Phase III</td>
<td>123</td>
</tr>
<tr>
<td>Pazopanib</td>
<td>Targets c-KIT, FGFR, PDGFR and VEGFR</td>
<td>Combination with Docetaxel</td>
<td>NSCLC patients who have received first-line therapy (NCT01208064) Refractory small cell lung cancer (NCT01253369)</td>
<td>Phase II/III</td>
<td>120</td>
</tr>
<tr>
<td>Vandetanib</td>
<td>MT-TKI, against VEGFR, EGFR and RET</td>
<td>Small increase in PFS in patients with NSCLC</td>
<td>Combination with Docetaxel</td>
<td>Phase III</td>
<td>[106,123-124]</td>
</tr>
<tr>
<td>Nintedanib</td>
<td>VEGFR, FGFR, PDGFR</td>
<td>Increased PFS and RR</td>
<td>Combination with Docetaxel</td>
<td>Phase III</td>
<td>123</td>
</tr>
</tbody>
</table>

NSCLC: non small cell lung cancer; SCLC: small cell lung cancer; VEGF: Vascular endothelial growth factor; EGFR: epidermal growth factor receptor; TRK: tyrosine kinase inhibitors; ALK: anaplastic lymphoma kinase; BRAF- V-RAF murine sarcoma viral oncogene homolog b1; PFS: Progrssive free survival; RR: respiratory rate; PDGFR-R: platelet derived growth factor receptor; CSF-1R: colony stimulating factor 1 receptor; FGFR: fibroblast growth receptor.

**Table 5: Summarizes drugs used in target therapy along with their FDA status**

**CONCLUSION**

One of the culprits for lung cancer is smoking. However, many patients continue to smoke even after diagnosis which places them at higher risk of treatment toxicity and cancer recurrence. The patients who continue to smoke must be offered interventions to help them quit. Lung cancer patients and their care givers need psychological support so that they are able to cope with the consequences of diagnosis and treatment. In patients with metastatic disease, palliative radiotherapy is effective for the management of pain and coughing up of blood or blood-stained mucus from the bronchi, larynx, trachea, or lungs. Patients at advanced stage should be provided palliative care. Early palliative care improves outcomes including survival of the patient. Chemotherapy along with surgery and radiation therapy is used commonly for the management of lung cancer.
Future perspective

In the past decades, chemotherapeutic drugs are widely used either in a single form or in combination and also associated with other therapies such as surgery, radiotherapy to improve the condition of the patient. Palliative and supportive cares are given to a patient also plays an important role in the recovering of tumor patients. But, each therapy has its own limitations such as chemotherapeutic agent is non-specifically distributed throughout the body where they affect both cancerous and non-cancerous cells, which cause various side effects such as rash, alopecia, severe liver, and kidney function decline, cardio-toxicity, bone marrow suppression and also quality of patient's life. In the current scenario, enormous advancement in the development and application of bioinformatics and nanotechnology has been developed for the detection, diagnosis, and therapy of cancer. The Development of nanotechnology has revolutionized the treatment of lung cancer to a very great extent and also formulates target specific formulation with a high affinity for cancer treatment. It also helps to overcome the drawbacks and lacking specificity in conventional therapies that are not possible with other types of therapeutic drugs, and have shown a bright future as a new generation of cancer therapeutics.

Financial and competing interest’s disclosure

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