

Optimal care pathway for people with lung cancer

Quick reference guide



Please note that not all patients will follow every step of this pathway:

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 1

Prevention and early detection

Prevention:

- All current smokers should be offered advice to quit smoking. **Effective strategies include:**
 - advice on quitting smoking and structured interventions by health professionals
 - individual or group counselling programs such as Quit (refer to www.quit.org.au)
 - nicotine replacement therapy and other pharmacological agents.

Risk factors:

- Lifestyle factor:
 - tobacco smoking
- Environmental factors:
 - passive smoking
 - radon exposure
 - occupational exposure (such as asbestos and diesel exhaust)
 - air pollution

• Personal factors:

- age
- family history of lung cancer
- chronic lung disease

Early detection: No form of population screening has been shown to improve lung cancer outcomes.

Step 2

Presentation, initial investigations and referral

Signs and symptoms:

The following unexplained or persistent signs or symptoms lasting more than three weeks (or less than three weeks in people with known risk factors) require urgent referral for a chest x-ray: unexplained haemoptysis **or** persistent new/changed cough, chest/shoulder pain, breathlessness, hoarseness, weight loss, finger clubbing, unresolved chest infection, abnormal chest signs, features suggestive of metastasis from a lung cancer, and signs of pleural effusion.

Persistent haemoptysis and/or signs of superior vena cava obstruction require urgent referral to a specialist linked to a multidisciplinary team. Massive haemoptysis and/or signs of stridor require immediate referral to an emergency department.

General/primary practitioner investigations:

Chest x-ray; if cancer is suspected refer immediately. Contrast spiral computed tomography (CT) of the chest and upper abdomen if the chest x-ray is clear and symptoms persist. Immediate referral if the CT is abnormal. Test results should be provided to the patient within one week. The first specialist appointment should take place within two weeks of referral.

Referral: Refer all patients with suspected or proven lung cancer to a specialist linked with a multidisciplinary team.

Communication – lead clinician to:¹

- explain to the patient/carer who they are being referred to and why
- support the patient and carer while waiting for specialist appointments.

Step 3

Diagnosis, staging and treatment planning

Diagnosis: May be obtained from bronchoscopy including endobronchial ultrasound (EBUS), CT-guided biopsy, excisional biopsy or biopsy of metastasis, or sputum cytology (rarely).

Staging: Radiological staging based on CT scan of the chest and upper abdomen and one of the brain. Other tests to confirm the cancer stage may include bronchoscopy, thoracoscopy, thoracotomy, mediastinoscopy, endobronchial/oesophageal ultrasound (EBUS/EUS) and nuclear medicine tests including bone and positron emission tomography (PET) scans, with biopsies to establish pathology.

Treatment planning: All patients with suspected or proven lung cancer should be discussed by a multidisciplinary team before treatment begins.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the patient/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

¹ Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.



Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/ or longevity without expectation of cure
- symptom palliation.

Surgery:

- Surgery will benefit people with early stage non-small-cell lung cancer (NSCLC) who are fit and those requiring surgical diagnosis or palliation.

Radiation therapy may benefit people with:

- NSCLC who are not suitable for surgery or have locally advanced disease and are being treated with combined modality therapy
- small-cell lung cancer (SCLC) having combined modality treatment or those who would benefit from prophylactic cranial irradiation.

All patients may benefit from radiation therapy for palliative intent.

Chemotherapy or drug therapy may benefit people with:

- advanced disease and good performance status
- NSCLC who are having neoadjuvant or adjuvant therapy in conjunction with completed resection of locoregional disease
- inoperable localised NSCLC who are considered suitable for combined modality definitive chemoradiation.

Palliative care: Early referral can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- discuss treatment options with the patient/carer including intent of treatment as well as risks and benefits
- discuss advance care planning with the patient/carer where appropriate
- discuss the treatment plan with the patient's general practitioner.

For detailed information see http://www.wiki.cancer.org.au/australia/Guidelines:Lung_cancer.

Step 5

Care after initial treatment and recovery

Cancer survivors should be provided with the following to guide care after initial treatment.

Treatment summary (provide a copy to the patient/carer and general practitioner) outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided.

Follow-up care plan (provide a copy to patient/carer and general practitioner) outlining:

- medical follow-up required (tests, ongoing surveillance)

- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the patient/carer
- inform the patient/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the general practitioner.

Step 6

Managing recurrent, residual and metastatic disease

Detection: Most residual or recurrent disease will be detected via routine follow-up or when the patient presents with symptoms.

Treatment: Where possible, refer the patient to the original multidisciplinary team. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

Palliative care: Early referral can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication – lead clinician to:

- explain the treatment intent, likely outcomes and side effects to the patient/carer.

Step 7

End-of-life care

Palliative care: Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the patient/carer
- establish transition plans to ensure the patient's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.