**Optimal care pathway for people with lung cancer**

**Prevention and early detection**

- 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.

**Presentation, initial investigations and referral**

- 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.

**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:**

1. discuss a timeframe for diagnosis and treatment with the patient/carer
2. explain the role of the multidisciplinary team in treatment planning and ongoing care
3. 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.
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)
- interventions and treatment plans from other health professionals
- supportive care services provided.

**Step 4**

**Treatment:** Establish intent of treatment:
- curative
- anti-cancer therapy to improve quality of life and/or prolong survival without expectation of cure
- symptom 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.

**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)

**Radiation therapy** benefits 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** benefits 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.

**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 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 patient’s general practitioner.

**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.


This work is available at: www.cancer.org.au/ocp