


# Oncological Treatment of Lung Cancer

## Pathway of Care

Kent & Medway Cancer Collaborative



Publication date	October 2022
Expected review date	October 2023
Version number	20
Version status	Final

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## 1.0 INTRODUCTION AND BACKGROUND

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This document has been written to provide guidance on the treatment of lung cancer in the Kent & Medway Cancer Collaborative. Reference should also be made to NICE clinical guideline NG122 March 2019 <https://www.nice.org.uk/guidance/ng122>

Radiotherapy schedules are as defined in the Kent Oncology Centre Quality System Clinical Protocols.

All patients will be considered for entry into a clinical trial (see [appendix A](#)).

See Collaborative chemotherapy prescribing protocols for details of chemotherapy / anti-cancer regimens.

All patients should be discussed within a multidisciplinary team meeting before commencing initial treatment. All patients will be reviewed and assessed and where appropriate (and of adequate performance status), offered chemotherapy and/ or radiotherapy, including Stereotactic Ablative Radiotherapy (SABR).

All chemotherapy regimens listed within this document are delivered at either Maidstone and Tunbridge Wells NHS Trust, Dartford and Gravesham NHS Trust, Medway NHS Foundation Trust or East Kent Hospitals University NHS Foundation Trust.

The thoracic oncologists provide a comprehensive service for NICE approved treatments. For those treatments which are not approved by NICE and are not commissioned locally or via the cancer drugs fund applications may be made where appropriate through the Individual Funding Request route. Some treatments may only be available within an “Additional Private Care” framework.

Please note, some of the drugs / doses recommended within this document are outside of the UK licensed marketing authorisation.

## 2.0 NON-SMALL CELL LUNG CANCER

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### 2.1 Molecular Testing in NSCLC

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The National Genomic Test Directory specifies which genomic tests are commissioned by the NHS in England, the technology by which they are available, and the patients who will be eligible to access a test. This is in development; molecular testing for lung cancer in Kent will evolve in line with this guidance. The NOG recommends testing of all non-squamous NSCLC for EGFR mutations, ALK translocations and ROS 1. We recommend PDL1 immunohistochemistry in all cases of advanced or recurrent NSCLC. Next generation sequencing should be arranged via the genomic hub.

### 2.2 Adjuvant Treatment

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For Stage IB (>4cm) to IIIB completely resected NSCLC with good performance status (WHO 0-1):

- Cisplatin or Carboplatin and oral Vinorelbine for 4 cycles
- Cisplatin or Carboplatin + I.V. Vinorelbine for 4 cycles
- Adjuvant radiotherapy in R1/R2 resection with positive bronchial margin and in selected cases of N2 disease
- Osimertinib for stage IB to IIIA or N2 only stage IIIB (T3 N2 or T4 N2) tumours with either an EGFR exon 19 deletion or an exon 21 (L858R) substitution mutation. Within 10 weeks following surgery or within 26 weeks of surgery and adjuvant chemotherapy. Maximum of 3 years treatment.
- Atezolizumab for the adjuvant treatment of completely resected stage IIB or IIIA or N2 only IIIB NSCLC which has PD-L1 expression at a level of  $\geq 50\%$  which has not progressed on adjuvant platinum-based chemotherapy (maximum 4 cycles). The chemotherapy should have been commenced with 12 weeks of the resection. Atezolizumab must be commenced within 12 weeks of the last cycle of adjuvant platinum-based chemotherapy. Maximum of 1 year of treatment.

### 2.3 Neo-Adjuvant Treatment

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Neo-adjuvant chemotherapy +/- radiotherapy may be offered for selected cases.

### 2.4 Palliative Treatment

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#### 2.4.1 Advanced NSCLC

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For guidance on the prescribing in advanced NSLC please refer to St Luke's chemotherapy algorithm:

<https://www.royalsurrey.nhs.uk/download.cfm?doc=docm93jjim4n12328.pdf&ver=29221>

NB Please check revision date of this document and refer to Blueteq for the most up to date commissioning criteria.

## 2.4.2 Subsequent Lines of Therapy

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It may be appropriate to offer further lines of therapy in selected patients who remain of good performance status (PS 0/1).

Choice of systemic anti-cancer therapy will be dictated by previous treatment. Some patients may benefit from re-challenging with platinum based chemotherapy.

Selected patients may be candidates for referral to a phase I clinical trial unit.

## 2.4.3 Palliative Radiotherapy

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Palliative radiotherapy is indicated for symptom control. Indications include painful bone metastases, symptomatic intrathoracic disease, and spinal cord compression (impending or developing) as well as intracranial metastases.

## 2.4.4 Management of Superior Vena Caval Obstruction (SVCO)

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In terms of the management of Superior Vena Caval Obstruction (SVCO) radiotherapy is no longer a first-line standard of care. Patients should be assessed for urgent SVC stenting through an appropriate interventional radiologist. Radiotherapy should be reserved for patients who cannot be stented for technical reasons. In the case of SVCO secondary to small cell lung cancer, primary chemotherapy is the treatment of choice.

## 2.5 Locally Advanced NSCLC

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Patients who are potentially suitable for radical treatment should all have a pre-treatment CT and CTPET scan and lung function tests and a staging MRI brain.

All chemoradiation patients should have a brain MRI.

If resectable at diagnosis, consider surgery plus adjuvant chemotherapy.

If unresectable at diagnosis or unfit for surgery, patients should be considered for radical radiotherapy or chemoradiation with:

- Vinorelbine + cisplatin
- Weekly paclitaxel + carboplatin followed by 3 weekly paclitaxel + carboplatin consolidation.

Concurrent chemoradiotherapy will be offered to selected cases of locally advanced inoperable NSCLC, (unresectable stage III and stage II unfit for surgery with PS 0 or 1) (NICE clinical guidance 2019).

In some situations, “sequential radical” or “sequential high dose palliative” chemoradiation may be more appropriate.

All potential radical patients should be discussed at the Radical Radiotherapy MDM.

### 2.5.1 Adjuvant Treatment for Unresectable NSCLC after Chemoradiation

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Durvalumab for PDL1 positive patients who have not progressed following platinum based chemoradiation therapy.

## 2.6 Early Stage Inoperable NSCLC

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Where surgery is not possible for early stage disease, radical radiotherapy will be considered.

Stereotactic ablative radiotherapy can be considered for patients T1 N0 M0, T2 (<5cm) N0 M0, T3 (<5cm) N0 M0 NSCLC based on positive histology, positive PET scan or growth on serial CT scan. These lesions should be Peripheral lesions outside a 2cm radius of the main airways and bronchial tree.

## 3.0 SMALL CELL LUNG CANCER GUIDELINES

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### 3.1 Overview

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Patients suitable for chemotherapy for SCLC should be prioritised for treatment and commence treatment as soon as possible, ideally within one week of initiation of action sheet.

For patients with bulky disease consider allopurinol for first cycle.

### 3.2 Extensive Stage (first line)

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- Atezolizumab in combination with carboplatin and etoposide for 4 cycles followed by maintenance atezolizumab monotherapy
- Carboplatin + Etoposide for up to 6 cycles
- Cisplatin + Etoposide for up to 6 cycles
- Responders will be offered treatment with prophylactic cranial irradiation (PCI) (after completion of chemotherapy + consolidation radiotherapy)
- Cisplatin/ carboplatin + irinotecan/ gemcitabine may be considered in rare cases eg allergic to etoposide (funding approval required)

### 3.3 Limited Stage (first line)

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Concurrent or sequential chemoradiation is the treatment of choice.

Sequential chemotherapy regimens include:

- Carboplatin + Etoposide for up to 6 cycles
- Cisplatin + Etoposide for up to 6 cycles
- Cisplatin/ carboplatin + irinotecan may be considered in rare cases e.g. allergic to etoposide (funding approval required)
- Thoracic radiotherapy and PCI after completing chemotherapy (sequential)

A pre-treatment PET and staging MRI brain will be performed prior to radical concurrent chemoradiation.

## 3.4 Further Lines of Chemotherapy on Relapse

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Options include:

- CAV for up to 6 cycles
- Oral topotecan for up to 6 cycles (NICE approved if re-treatment with the previous treatment is not considered appropriate and there is a medical reason why the patients cannot have CAV. Other indications funding approval required).
- ACE for up to 6 cycles
- Consider platinum rechallenge in patients who have a durable response to first-line treatment

## 4.0 MALIGNANT MESOTHELIOMA

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### 4.1 Overview

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Supportive care including optimal management of effusion as per BTS guidelines.

Surgical VATS pleurodesis for effusions.

If localised and of good performance status, consider referral for surgery.

#### 4.1.1 Chemotherapy

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Consider systemic treatment.

First line:

- Cisplatin + pemetrexed up to 6 cycles.
- Carboplatin + pemetrexed up to 6 cycles.
- Bevacizumab (funding approval required) may be added to the above protocols.
- Ipilimumab and nivolumab

Other regimens which may be considered as alternative 1st line or as 2nd line include:

- Cisplatin + gemcitabine for up to 6 cycles
- Single agent vinorelbine I.V. or oral
- Nivolumab 2nd line treatment (the option to give nivolumab monotherapy instead of second-line chemotherapy to reduce the risk of immunosuppression only remains in place for patients who started first-line chemotherapy on or before 14 July 2022, when the only first-line option available was chemotherapy).

## 5.0 MALIGNANT THYMOMA / THYMIC CARCINOMA

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### 5.1 Overview

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The management of thymoma is surgical wherever possible. Chemotherapy and radiotherapy may be considered for selected patients following MDT discussion as out-lined below.

#### 5.1.1 Chemotherapy

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Chemotherapy with CAP may be indicated as follows: -

- Unresectable disease
- Pre-operative for downstaging.
- Post-operative if R1/R2 resection

#### 5.1.2 Radiotherapy

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Radiotherapy may also be considered in both pre and post-operative settings as well as palliatively.

## 6.0 BISPHOSPHONATES & DENOSUMAB FOR BONE METASTASES

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Bisphosphonates reduce skeletal morbidity associated with bone metastases (Hillner et al, 2000; Lipton et al, 2000).

All patients with bone metastases should be considered for treatment, especially those:

- Patients with lytic bone metastases on plain radiographs.
- Patients with symptomatic bone metastases (with appropriate use of palliative radiotherapy and analgesics).
- Patients who have suffered a previous skeletal event (pathological fracture, previous radiation to a painful bone metastasis).

Choice of therapy:

- Pamidronate may be given 3 or 4-weekly (with or without chemotherapy).
- Zoledronic acid is more effective than Pamidronate at reducing skeletal complications (Rosen et al, 2001).
- Denosumab is recommended as an option for preventing skeletal-related events in adults with bone metastases if bisphosphonates would otherwise be prescribed.



## 7.0 NEUROENDOCRINE TUMOURS OF LUNG ORIGIN

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Well differentiated NETs of lung origin will be treated in accordance with the neuroendocrine algorithm / protocols as set out in the Upper GI Oncological Treatment Guidelines.

## 8.0 APPENDIX A: CLINICAL TRIALS

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Refer to the local research team who will provide on request an orientation handbook, list of current trials and associated trial protocols and summaries. We are keen to support any trials supported by the NCRI locally within Kent but also refer to outside centres.

### Contact numbers

<b>MTW – Clinical Trials Office</b>	01622 225 033
<b>Darent Valley Hospital – Clinical Trials Office</b>	01322 428 100 ext 4810
<b>Medway Hospital – Clinical Trials Office</b>	01634 825 094
<b>East Kent Hospitals – Clinical Trials Office:</b>	
Solid Tumours	01227 866 393
Gynae Clinical Trials	01843 234343
Haematology Clinical Trials	01227 864129

## 9.0 APPENDIX B: EGFR TKI THERAPY IN NSCLC

### Management of Dermatological Adverse Effects of EGFR Tyrosine-Kinase Inhibitors in NSCLC

#### General advice

- Provide patient education about prevention and management of skin adverse effects before EGFR TKI treatment starts. Explain that rash is not acne.
- Prevention: moisturise at least twice daily; use emollients (e.g. E45, diprobase cream, epaderm ointment) and soap substitutes (e.g. dermol 500 lotion, oilatum shower gel)
- Protect against excessive exposure to sunlight; use SPF 30 UVA and UVB protective sunscreen.

#### CTC 4.0 Papulopustular Rash Grading

Grading	Description
0	None
1	Papules and/or pustules covering <10% body surface area (BSA), which may or may not be associated with pruritus or tenderness
2	Papules and/or pustules covering 10-30% BSA, which may or may not be associated with symptoms of pruritus or tenderness; associated with psychosocial impact; limiting instrumental ADL
3	Papules and/or pustules covering >30% BSA, which may or may not be associated with symptoms of pruritus or tenderness; limiting self-care ADL; associated with local superinfection with oral antibiotics indicated
4	Papules and/or pustules covering any % BSA, which may or may not be associated with symptoms of pruritus or tenderness and are associated with extensive superinfection with IV antibiotics indicated; life-threatening consequences

#### Management of Rash

Severity of rash	Management plan
<b>Grade 1 toxicity</b> (Mild)	<ul style="list-style-type: none"> <li>● Continue EGFR TKI at current dose</li> <li>● Continue to moisturise regularly (check compliance and change emollient if necessary)</li> <li>● Consider topical antibiotics (1% clindamycin lotion) and/or topical steroids (1% <u>or</u> 2.5% hydrocortisone cream)</li> <li>● Use recommended appropriate shampoos if scalp affected (e.g ketoconazole, betadine or ceanel shampoo)</li> </ul>
<b>Grade 2 toxicity</b> (Moderate)	<ul style="list-style-type: none"> <li>● Continue EGFR TKI at current dose unless intolerable</li> <li>● Continue to moisturise regularly and intensify emollient use</li> <li>● Apply short term topical steroids (hydrocortisone 2.5% cream <u>or</u> pimecrolimus 1% cream as steroid sparing agent)</li> <li>● Apply short-term topical antibiotics (1% clindamycin cream)</li> <li>● Use oral antibiotic course (tetracycline for 2 weeks: oxytetracycline 500mg bd <u>or</u> lymecycline 408mg od) * *Prescribe as per Trust formulary</li> <li>○ <b>Note:</b> Avoid doxycycline as associated with photosensitivity</li> <li>● Consider antihistamines</li> </ul>
<b>Grade 3 toxicity</b> (Severe)	<ul style="list-style-type: none"> <li>● Discontinue EGFR TKI and only reinstate (at reduced dose) when skin has resolved to grade 2 or less.</li> <li>● Manage as for grade 2</li> <li>● <b>Seek dermatology advice.</b></li> <li>● Fax urgent referral to local Dermatology service.</li> </ul>

Produced by Dr Lianne Thomas (CT2 Oncology) and Dr Maher Hadaki (Consultant Clinical Oncologist)

Adapted from Califano et al 2015: Expert Consensus on the Management of Adverse Events from EGFR tyrosine kinase inhibitors in the UK and Thatcher et al 2009: Expert Consensus on the Management of Erlotinib-Associated cutaneous toxicity.

## 10.0 PERSONNEL AND CONTACT INFORMATION

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A comprehensive, up to date list of MDM contact details can be requested by NHS professionals by contacting the Kent & Medway Cancer Collaborative. Their contact telephone number is 01233 651905.

## 11.0 GLOSSARY

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Acronyms in common usage throughout KMCC documentation

BNF	British National Formulary
BOPA	British Oncology Pharmacist Association
CNB	Cancer Network Board
COSHH	Control of substances hazardous to health regulations.
CYP	Children & Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TSSG/TWG)
DVH	Darent Valley Hospital
DGT	Dartford and Gravesham NHS Trust
EK	East Kent
EKHUFT	East Kent Hospitals University Foundation Trust
EPS	Electronic Prescribing System
FP10(HNC)	Prescriptions issued by hospital doctors for dispensing in the community
GP	General Practitioner
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
IV	Intravenous
K&C	Kent & Canterbury Hospital, Canterbury, (EKHUFT)
KMCC	Kent & Medway Cancer Collaborative
KMCRN	Kent & Medway Cancer Research Network
KOMS	Kent Oncology Management System
LSESN	London & South East Sarcoma Network
MFT	Medway Foundation Trust
MTW	Maidstone & Tunbridge Wells NHS Trust
NHS	National Health Service
NMP	Non-medical prescriber
NPSA	National Patient Safety agency
NOG	Non Surgical Oncology Group <i>(Permanent oncologist sub group of the DOGs with a specific responsibility for chemo/rad pathways and advice to the DOG, Network and GEOGRAPHICAL LOCATIONS on new drugs)</i>
PoC	Pathway of Care <i>(Network agreed disease site specific clinical guidelines)</i>
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
QSI	Quality service information system
QST	Quality Surveillance Team
RAT	Research and Trial Group

	<i>(Permanent sub-group of the DOGs with a specific responsibility for taking forward the clinical trials agenda)</i>
RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
SACT	Systemic Anti-Cancer therapy
SACT regimen	Systemic Anti-cancer prescription on the electronic prescribing system
SACT protocol	Systemic Anti-cancer protocol on KMCC website
TTO	Treatment to take home
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

## 12.0 DOCUMENT ADMINISTRATION

<b>Document Title</b>	Oncological Treatment of Lung Cancer
<b>Principle author</b>	Lung NOG
<b>Co-author(s)</b>	Caroline Waters
<b>Current version number</b>	19
<b>Current status</b>	Final
<b>Expected review date by</b>	2023

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<b>Revision History</b>			
Date of revision	New Version Number	Nature of Revision	Confirmation of Accuracy by
March 2009	V1	Version one, document created	Lung NOG
December 2009	V1.1-1.5	Document revised to incorporate numerous changes mainly around NSCLC pathway	Lung NOG
January 2010	V2	Revised document approved by Lung NOG	Lung NOG
February 2010	V2.1	Changes as per summary of changes form (to be added as a separate document)	Lung NOG
April 2010	V3	Published	Lung NOG
July 2010	V4	Document revised to incorporate agreed changes	Lung NOG
December 2010	V4.1	Changes to sections 1.2, 1.5 (prev 1.4), 2.1, 2.2, 3.1, 3.1.1, appendix B Addition of section 1.3	Lung NOG
December 2010	V5	Published	Lung NOG
March 2011	V5.1	Document revised to incorporate agreed changes	Lung NOG
April 2011	V6	Published	Lung NOG

September 2011	V6.1-6.2	Changes to section: introduction, 1.4.1.1, 1.5 2.1, 2.3, Appendix B	Lung NOG
October 2011	V7	Published	Lung NOG
November 2011	V7.1	Changes to section 1.4.2.3 – maintenance therapy for NSCLC	R Shah
December 2011	V8	Published	R Shah
March 2012	V8.1	Changes to sections 1.4.2.1 and 1.4.2.3, 2.3 and 2.4.	Lung NOG
April 2012	V9	Published	Lung NOG
November 2012	V9.1	Document revised and addition of section on bisphosphonates	Lung NOG
February 2013	V10	Published	Lung NOG
June 2013	V10.1	Updated in line with NCDF list indications	
July 2013	V11	Published	Lung NOG
May 2014	V11.1	Afatinib added under treatment of metastatic NSCLC	Lung NOG
June 2014	V12	Published	Lung NOG
September 2014	V12.1	Addition of statement to section 2.4.2.1 and 2.4.2.2. regarding commissioning of erlotinib in patients unable to receive docetaxel.	
October 2014	V13	Published	M Cominos
April- Oct 2015	V13.1	Document reviewed by the Lung NOG and updated in line with changes to the NCDF List, commissioning arrangements for molecular testing and NICE TA 347	
October 2015	V14	Published	M Cominos
May – Dec 2017	V14.1-14.7	Updated with NICE guidance and changes to NCDF process On-going revision of section 2 Updated Appendix B Addition of section on NETs of lung origin Addition of 1st line ceritinib	M Cominos & Lung NOG
December 2017	V15	Published	M Cominos
May 2018	V15.2	Section 2.4.1 Atezolizumab added	C Waters
November 2018	V15.4	Section 2.4.2 addition of carboplatin. Addition of pembrolizumab/pemetrexed and pembrolizumab/cisplatin/carboplatin/pemetrexed New section: 2.5.1 Maintenance/adjuvant TX for unresectable NSCLC after chemoradiation.	M.Archer From NOG
January 2019	V16	Published	
May 2019	V16.1	Addition of Atezolizumab in combination with bevacizumab, paclitaxel and carboplatin (EAMs scheme)	
June 2019	V16.2-16.3	Section: 1.0 Addition of NICE reference Section 2.1 inclusion of ROS 1 Section 2.4 Changed, to include reference to St Luke's treatment algorithm Section 2.5 and 2.5.1 updated Section 3.2 and 3.3 updated Re formatted following significant changes	M.Archer From NOG

September 2019	V17	Published	M.Cominos
November 2019	V17.1	<p>Amendments to section:            2.5 staging MRI added            2.5.1 change of title            3.2 amendment to point 4            3.3 addition of 'and staging MRI brain'            4.1 addition of ' good performance status'            4.1.1 addition of ' Cisplatin + pemetrexed up to 6 cycles/Carboplatin + pemetrexed up to 6 cycles/Bevacizumab (funding approval required) may be added to the above protocols.'            Removal of ' Cisplatin + raltitrexed for up to 6 cycles. – funding approval required'</p>	<p>M.Archer            From NOG 19/11/19</p>
November 2020	V17.2	<p>NOTE due to the COVID 19 pandemic V17.1 was not reviewed following changes:            Amendments to section:            1.0 typo corrected            2.1 updated guidance for genomic testing            2.5 updated treatment option            4.1.1 immunotherapy added</p>	<p>M.Archer            From NOG            10/11/20</p>
November 2020	V17.3	Above changes and formatting corrected sent to TS for approval	M.Archer
November 2020	V18	Reformatted by R.Patel Published	T.Sevitt
May 2021	V18.1	Genomic testing as standard Immunotherapy merged in to treatment pathway Chair of NOG updated	<p>M.Archer            Updated at NOG            18.05.21</p>
June 2022	V18.2-V18.2.1	Reviewed at Lung NOG St lukes algorithm add new link.	<p>M.Archer            Updated at NOG</p>
September 2022	V19	Published	T.Sevitt
October 2022	V19.1	Section 2.2 carboplatin added osimertinib and atezolizumab updated. 4.1.1 Chemotherapy nivolumab updated	<p>Lung NOG            18.10.22            Updated by M Archer</p>
October 2022	V20	Published	T.Sevitt