

The Management of Lung Cancer

Pathway of Care

Publication date	February 2023
Expected review date	February 2025
Version number	7.0
Version status	FINAL

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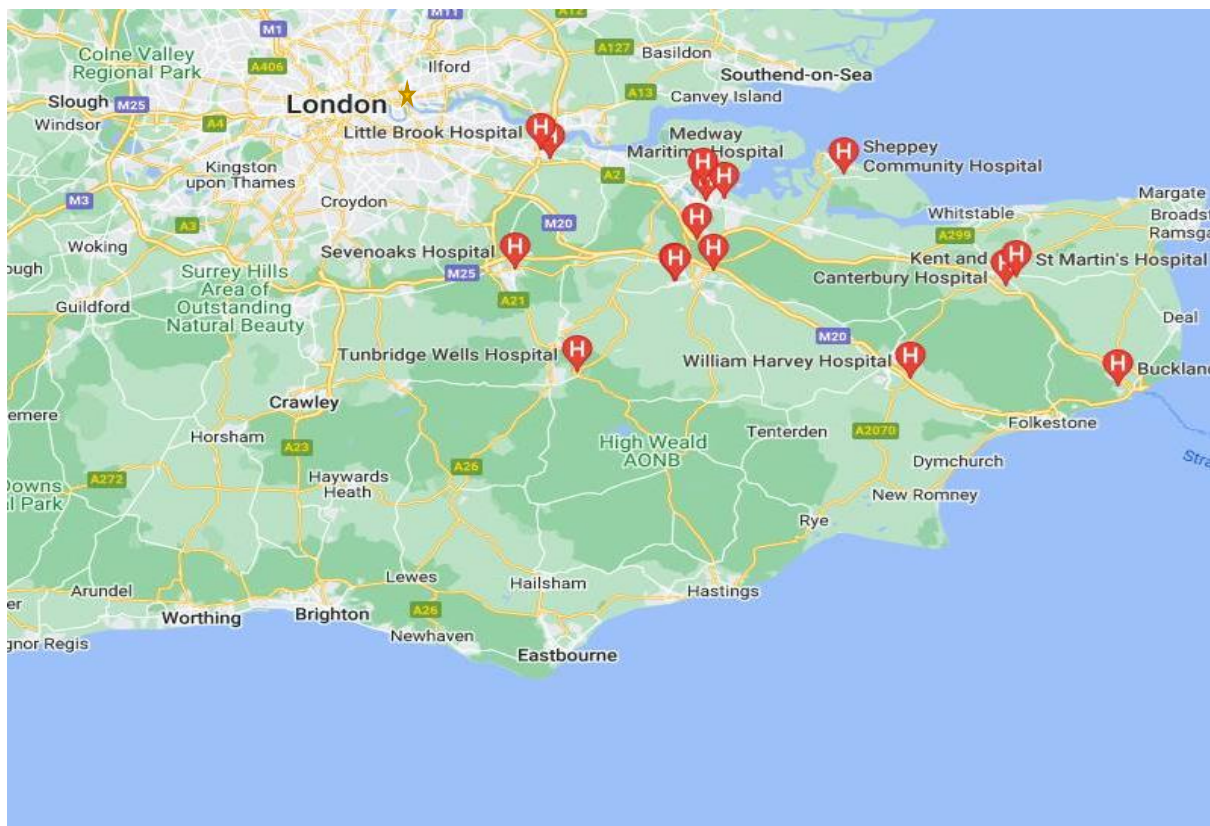
1.0 Background

1.1 Lung Cancer is the 3rd most commonly diagnosed cancer in England, but accounts for most deaths. The United Kingdom has a low lung cancer survival when compared to its European counterparts. Patients diagnosed with lung cancers in the UK have a poorer prognosis because:-

- They present late to medical practitioners
- They often have significant co-morbidity, e.g. chronic cardiorespiratory problems which preclude definite therapy
- There may be delays in diagnosis once referred

1.2 Kent and Medway has an adult population of approximately 1.5 million. In 2019, a total of 1448 new cases of lung cancer were diagnosed. The region has reported a lower 1- and 5-year survival from lung cancer, compared to England averages (38.5% vs 41.9% for 1 year; 15.0% vs 17.9% for 5 years)

- 1.3 The Lung TSSG is committed to improving the outcome of patients with lung cancer by :-
- a. encouraging early referral from primary care of “at risk” patients
 - b. providing a rapid & comprehensive local pathway for investigation and treatment of these patients, and
 - c. complying with the NICE guidelines for the management of Lung Cancer³



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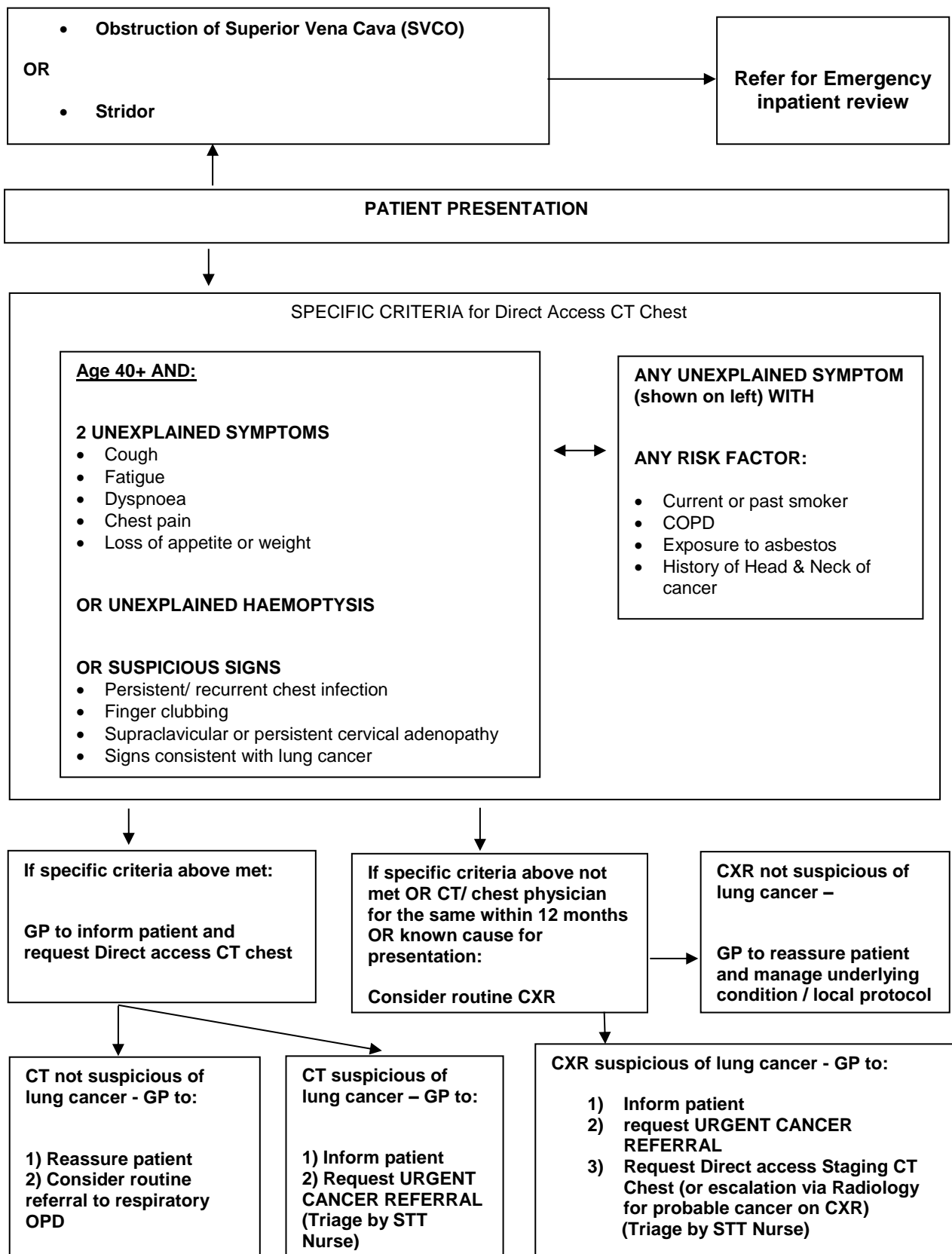
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2.0 Overview

- 2.1 In describing a model of care for patients presenting with suspected / proven lung cancer or mesothelioma, the TSSG has endeavoured to reconcile the following views:
- Calman – Hine / Cancer Reform Strategy recommendations that patients should be managed as closely to home as possible.
 - To improve the outcomes in lung cancer by co-ordinating the treatment of specialist teams, i.e.:
 - Initial investigations by local respiratory team (in accordance with the NOLCP)
 - Referral for thoracic surgery to Guy's Hospital (GSTT)
 - Referral for Radiotherapy / SACT at the Kent Oncology Centre at Maidstone Hospital (MTW) and the William Harvey Hospital in Ashford (EKHUFT)
- 2.2 More recently the TSSG has benefitted from local review⁵ by the Get It Right First Time (GIRFT) team, who highlighted some areas of commendable practice in the region as well as local processes that would benefit from further audit and regular review
-

3.0 Overview Referral Pathway for Primary Care



3.1 General Practitioners are encouraged to arrange an urgent chest X-ray for patients in the following circumstances:

- Smokers who present with new respiratory symptoms
- Smokers who complain of persisting cough or increasing shortness of breath of ≥ 3 weeks duration
- Any patient over the age of 40 who presents with haemoptysis and progressive shortness, weight loss or chest/shoulder pain without an obvious cause
- Hoarseness
- Finger clubbing
- Features suggestive of lung metastases
- Persistent cervical/supraclavicular lymphadenopathy
- Features suggestive of pleural effusion

3.2 GPs should counsel patients beforehand why they are being referred for an urgent chest X-ray

3.3 In cases where the chest X-ray is suggestive of cancer:

1. results to be urgently (preferably by phone and to the GP in person) relayed to the GP to make an urgent 2WW referral (OR)
2. results sent directly to the local 2WW lung cancer clinic. Local arrangements will be in place to ensure that the GP and the patient are aware that a 2WW referral has been made and that this may well include moving straight to CT scan before the outpatient appointment

In cases where the chest X-ray is NOT suggestive of cancer:

1. results to be communicated to the GP for management in primary care or a recommendation for a routine referral to the local specialist chest clinic

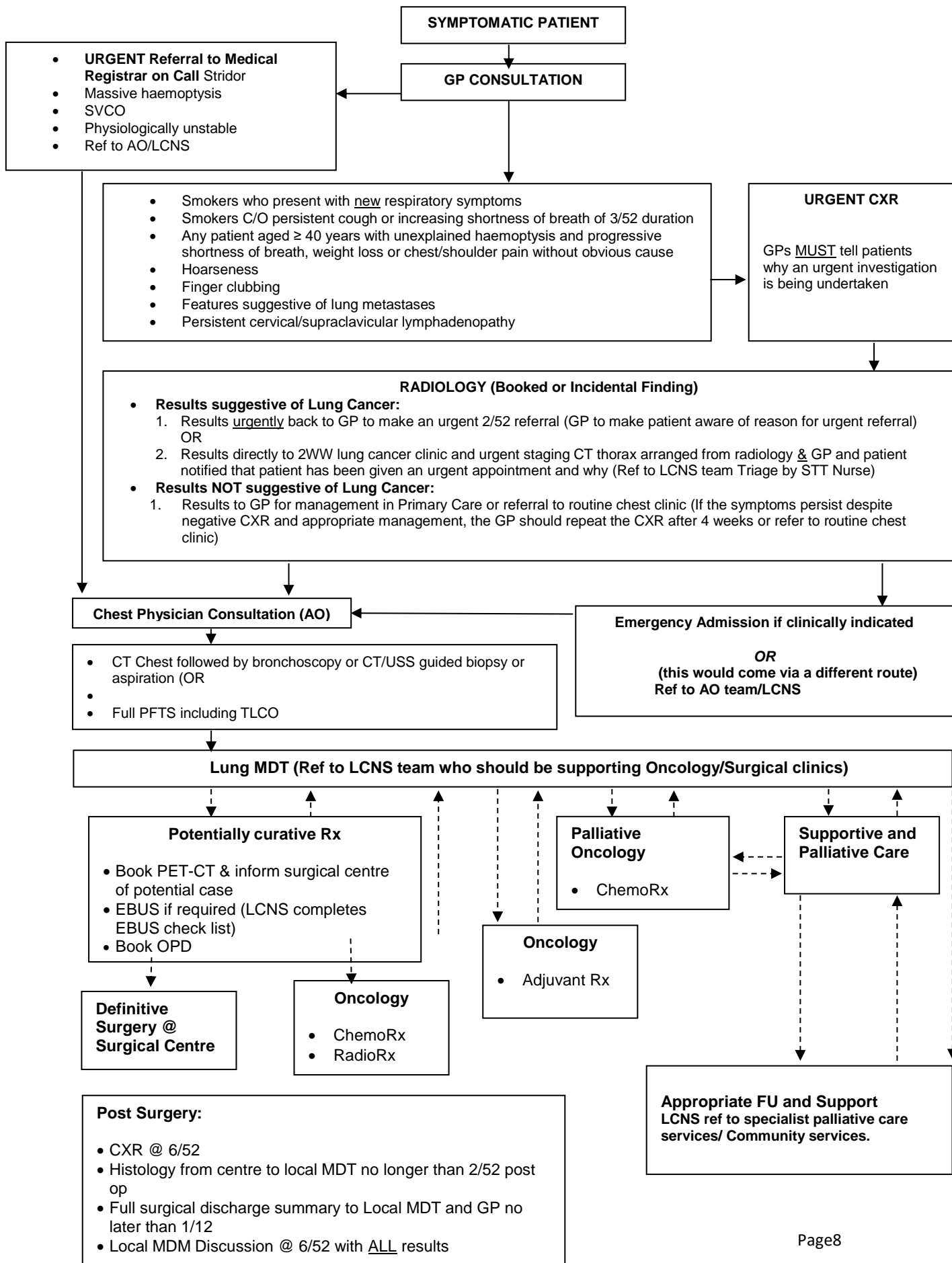
Note: If symptoms (e.g. cough) persist despite a normal chest X-ray and appropriate management, the GP should repeat the CXR after 4 weeks or make a referral to the local chest clinic. A negative chest X-ray should not be taken as an indication that lung cancer is not present, as most operable lung tumours are not visible on plain radiographs.

3.4 Criteria for urgent 2WW referral

1. Unexplained haemoptysis in smokers / ex-smokers (more than 15 pack years) over the age of 40

2. Signs of Superior Vena Cava Obstruction (SVCO) - consider emergency admission to hospital
 3. Stridor – consider emergency admission to hospital
 4. Chest X-ray suggestive of lung cancer – including a non-resolving pleural effusion or consolidation on repeat CXR
 5. 2WW referral should be accompanied by Direct-access CT (where available). Where local arrangements are not available for this, it should be requested by the local 2WW triage service.
-

4.0 Pathway Overview for Secondary Care



4.1 Whilst the Lung Tumour Site Specific Group (TSSG) sets its targets in accordance to the “Improving Outcomes – a Strategy for Lung Cancer” directive¹ (IOG, January 2011), more recently it has agreed to adopt the National Optimal Lung Cancer Pathway² (NOLCP, 2017) which now provides more stringent timeframes for diagnosis and treatment of lung cancer in patients referred from their GPs. The TSSG therefore is working with local lung multidisciplinary teams and key stakeholders to ensure that these timelines are met, without compromising the care or experience of patients who are on this pathway.

4.2 A flow diagram of the key timelines is provided in Appendix 1.

4.3 Local specialist chest clinic

4.3.1 Patients referred under a 2-Week Wait (2WW) lung cancer pathway should be triaged by a member of the Lung MDT, with the aim to be seen within two weeks. Ideally this should be the respiratory consultant or lung cancer CNS / Straight to test (STT) nurse managing the local specialist chest clinics.

4.3.2 The aim of a STT pathway is to ensure baseline 2WW investigations like Staging CT and baseline investigations have been requested and ideally *performed before the date of clinic appointment*. Depending on local arrangements this can also be expanded to include a straight-to-biopsy pathway when the patient is triaged as being suitable but not fit for radical treatment.

4.3.3 Patients in whom a diagnosis of lung cancer is considered likely on triage should be seen with a staging CT at the time of assessment. The CT report should ideally be available at the time of appointment with the reporter specifically noting the provisional staging of the tumour and preferred biopsy site(s).

4.3.4 At the first outpatient review, a comprehensive assessment of the patient's performance status (PS) and tumour resectability along with a review of surgical suitability should be undertaken. These factors should be discussed with the patient (and carers) during this appointment. The discussion with the patient should also document disclosure of a possible diagnosis, provisional staging, treatment options and an assessment of the patient's wishes at this stage.

4.3.5 Patients deemed fit for radical treatment (PS0/1) with no significant comorbidity will additionally require the following investigations:

- Full Lung function Tests with Transfer factor
- Fibre-optic bronchoscopy and / or percutaneous lung biopsy
- EBUS/ CTPET for staging
- In some cases, a 6MWT

4.3.6 Other investigations to be performed at the time of the clinic appointment will include:

- Full blood count
- Creatinine and electrolytes
- Serum calcium
- Liver function tests
- Electrocardiogram +/- echocardiogram
- Coagulation profile

4.3.7 Following clinical review, an MDT discussion should occur ideally *after the biopsy results and PET scan are available*. Where obtaining a tissue diagnosis is technically difficult or in patients with a potentially resectable lung nodule, the MDT should consider whether proceeding to surgery prior to histological confirmation of lung cancer is appropriate. The Thoracic Surgeon should be present for these MDT discussions, and prioritisation of MDT caseload at the weekly meetings is recommended for this purpose.

4.3.8 For Patients with borderline fitness (PS2/3), every reasonable attempt should be made to do the following:

- Referral for Pre-habilitation to optimise Performance Status prior to surgery
- Referral to relevant specialities to optimise co-morbidities (e.g. coronary artery disease)
- Provide Smoking Cessation advice

These patients should be discussed by the MDT to gain consensus on preferred treatment and observed closely after the above interventions to re-assess suitability of treatment.

A. Non Small Cell Carcinoma:

If PET scan shows that the tumour is non-resectable, or the patient is subsequently deemed non-resectable after surgical assessment, referral to second MDM is appropriate for radiotherapy and / or chemotherapy and / or palliative care should be sought.

B. Small Cell Carcinoma:

Patients with small cell carcinoma with good performance status (PS0/1) should be referred directly for chemotherapy. This should be undertaken at the local cancer unit or at the Kent Cancer Centre at Maidstone Hospital.

4.3.10 Following initial MDT discussion, the patient should be contacted and a treatment plan outlined (e.g. referral to Thoracic Surgeon, Oncologist, Radiotherapist or Specialist Palliative Care Team). This can be done face-to-face or via telephone by the respiratory consultant or LCNS, depending upon the individual patient wishes and needs.

5.0 Pathology

Note: All Kent & Medway (K&M) reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the K&M Cancer website:-

<http://www.ekhft.nhs.uk/patients-and-visitors/services/pathology/>

<https://www.rcpath.org/profession/guidelines/cancer-datasets-and-tissue-pathways.html>

6.0 Imaging

The imaging guidelines for lung cancer are in the process of being updated regionally. The Lung TSSG adheres to the TNM staging for lung cancer as proposed by the International Association for the Study of Lung Cancer (IASLC) Staging and Prognostic Factors Committee. The next update of the current IASLC guidelines are due to be published in 2024.

7.0 Surgical Referrals

7.1 Non-Small Cell Carcinoma

7.1.1 Surgery should be offered to all patients who are medically fit and suitable for treatment with curative intent. This includes:

- _Stage Ia (T1aN0M0 and T1bN0M0)
- _Stage Ib (T2aN0M0)
- _Stage IIa (T2bN0M0 and T1–2aN1M0)
- _Stage IIb (T3N0M0 and T2bN1M0)
- _Stage IIIa (T3N1M0).

7.1.2 Consider surgery in selected patients with:

- _Stage IIIa (T4N0-N1M0).

7.1.3 Consider surgery as part of radical multimodality management in selected patients with:

- _Stage IIIa (T1–3N2M0 where N2 is single zone, non-fixed and non-bulky)
- _Adenocarcinoma in-situ (formerly bronchioloalveolar carcinoma).

Anatomical lung resection should be offered to suitable patients with single-site bronchioloalveolar carcinoma.

Multiple wedge resections may be considered in patients with a limited number of sites of bronchioloalveolar carcinoma

7.1.4 In assessing the fitness of patients for surgery, consideration should be given specifically to operative mortality, the risk of perioperative myocardial events and the risk of post-operative dyspnoea, indicating whether these risks are low, moderate or high to the patients. Baseline cardiac risk assessment should be undertaken and if necessary early referral to a cardiologist for evaluation and optimisation of cardiac function.

7.1.5 Respiratory morbidity of surgery should be assessed with lung function testing including TL_{CO}. Surgical resection should be offered to patients with low risk of post-operative dyspnoea. Surgical resection may be offered to patients at moderate to high risk of post-operative dyspnoea and associated complications if it is felt that this is the better treatment option, and the patient is willing to accept the higher risk

7.1.6 Some patients with localised tumours that are determined non-resectable will be suitable for radical radiotherapy / chemoradiotherapy.

7.2 [Small Cell Carcinoma](#)

- 7.2.1 The majority of patients with small cell lung cancer will be offered chemotherapy +/- radiotherapy. However selected patients with localised small cell carcinoma (T1-3N0M0), especially if there is any diagnostic doubt, may be considered for surgery. Surgical management of patients with T1-3N1-2M0 small cell lung cancer should only be considered in the context of a clinical trial.

7.3 [Malignant Mesothelioma](#)

- 7.3.1 Surgery for Malignant Mesothelioma is rarely curative. Therefore, surgical treatment options for this cancer will depend on a number of things including the type of mesothelioma, how advanced the disease is, the general health and fitness of the patient and their personal preferences.
- 7.3.2 All patients being considered for Malignant Mesothelioma should be discussed at a regional specialist multi-disciplinary team as they may be eligible for enrolment into a clinical trial. Currently, only two surgical trials have been performed which found that neither extensive (extra-pleural pneumonectomy) or limited (partial pleurectomy) surgery improved survival (although there was some evidence of improved quality of life).

7.4 [Referral to surgical centre](#)

The thoracic surgical centre for Kent and Medway is Guy's and St. Thomas' Hospital (GSTT). Cardiothoracic surgeons from GSTT are named core team members for all the K&M lung cancer MDTs.

Note: Contact details for the surgical team can be accessed via the following link:

<http://www.kmcc.nhs.uk/resource-library/>

7.5 [Overview of surgical pathway](#)

Note: Surgical pathway details can be accessed via the following link:

<http://www.kmcc.nhs.uk/resource-library/lung-tssg/>

8.0 [Non-Surgical Oncology Management](#)

The Non-surgical oncology management of lung cancer has been agreed (and is regularly updated) by the Lung Cancer Non-Surgical Oncology Group (NOG). A copy of the K&M oncological guidance documentation is located on the K&M Cancer website on the following link:-

<http://www.kmcc.nhs.uk/medicines-and-prescribing-incorporating-sact-pathways/oncological-treatment-guidelines/>

9.0 Research and Audit

The Kent Oncology Centre remains active in thoracic oncology trials. The department has recently completed accrual in to the BEAT-meso trial and was one of the highest recruiting centres nationally. In the post pandemic recovery phase there have been staffing issues that have reduced the potential for taking on further clinical trials however this is an issue that is being actively addressed. The department is active in performing regular audits and benchmarking exercises. They have submitted presentations to The British Thoracic Oncology Group Annual Meeting as well as partaking in quality assurance reviews of radiotherapy and systemic lung cancer treatment outcomes.

10.0 Supportive & Palliative Care

10.1 Patients with Non-Small Cell Lung Carcinoma who are deemed inoperable, those with Small Cell Lung Carcinoma with extensive disease and patients with Malignant Mesothelioma should be considered for palliative treatment. The prime aim of the treatment is to alleviate symptoms.

10.2 Patients with symptomatic pleural effusions should have an aspiration of the effusion performed; if this provides effective symptom relief, a chemical pleurodesis should be considered. If this is unsuccessful then placement of an indwelling pleural catheter (e.g. PleurX) may be helpful.

Patients may be referred for pleurodesis where there is local provision for medical thoracoscopy, or alternatively for video-assisted thoracoscopy (under a general anaesthetic) at GSTT.

10.3 Patients with haemoptysis and / or bone pain due to metastatic disease should be referred to Oncology for consideration of palliative radiotherapy. This can be provided at the Kent Oncology Centre based at Maidstone Hospital, or at Ashford Hospital.

10.4 Large airway obstruction and SVCO may require temporary placement of stents to relieve symptoms. The local Acute Oncology Service (AO) should be contacted during working hours for advice and support on further management. The Surgical Team at GSTT should be the first point of contact for consideration of airway stenting in tracheal / large airway obstruction. Local interventional radiology departments will provide contact details of access to vascular stenting (including out-of hours services for patients presenting via the Emergency Department)

10.5 Palliative care provision should be made for all patients:

- Hospital teams, including the Clinical Nurse Specialists for lung cancer patients
- Primary Health Care Team (including local hospice community and district nurse teams) would provide for palliative care at home
- GP should be informed within 24 hours of the diagnosis, of the treatment plan and medication.

10.6 The management of symptoms, psychological, social and spiritual issues, the communication of the diagnosis, and any associated problems should be within the domain of all health care professionals.

10.7 Referral to in patient or outpatient specialist palliative care services should be considered when these issues have not been resolved, in particular for patients with:

- Complex symptom management issues, which are difficult to manage
- Difficulties in adjusting to the diagnosis or disease progression
- Psychological and family issues – such as communication problems within the family
- Spiritual issues – such as the challenging of belief system/faith/cultural values as a result of the cancer

10.8 Community palliative care support is provided by the local hospice community teams. Consideration of specialist palliative care or support should be given throughout the patient pathway, in particular:

- At the MDT meeting
- When no active treatment is considered
- After active treatment
- At relapse
- In the terminal stages of cancer

11.0 Follow Up

11.1 The aim of ongoing surveillance should be the support of the patient and family, the timely and appropriate management of suspected disease progression and the ongoing management of individuals with pleural effusions from Cancer of an Unknown Primary (CUP).

11.2 All patients who have received treatment for their cancer will have open access to the Lung CNS / Meso UK CNS by telephone and, if necessary, be reviewed at a nurse-led clinic. The Nurse will assess and arrange for the investigation(s) and referral to a Chest Physician, Oncologist or the Specialist Palliative Care Team, if deemed appropriate. Routine follow-up appointments for these individuals should be discouraged and this should be clearly explained to patients, with the offer of open access contact with their Lung CNS for advice and support when required.

11.3 All patients who are receiving / have completed radiotherapy or chemotherapy should have regular contact with their oncologist and LCNS during the treatment schedule and one clinic appointment following their last treatment.

11.4 Pleural effusions where a clinical suspicion of Mesothelioma is considered likely (but not biopsy proven) by the MDT should have ongoing surveillance by a Chest Physician or LCNS in their local hospital.

11.5 5year Post Surgery Follow up. Following a surgical resection, there should be regular follow up for patients 6 weeks, and subsequently 6 monthly up to 5 years. Provision of clinic follow-up will be decided by individual trusts and local protocols. Patients should be nevertheless evaluated clinically and radiologically with chest X-rays as the first line imaging, and CT annually, or if there are symptoms or signs to suggest cancer recurrence.

11.6 Patients who have received palliative treatment may be referred to the Specialist Palliative Care Team. The LCNS should remain the point of contact for the team and the patient, until arrangements for hospice care have been agreed.

11.7 A Holistic Needs Assessment⁶ (HNA) will be undertaken for each patient during their pathway, to identify key areas that individuals with a new cancer diagnosis are troubled by the most, and from whom additional support can be provided for by members of the extended multidisciplinary team.

12.0 Children and Young People (CYP)

12.1 Children and young people with lung cancer will be treated in accordance with principles set out in the CYP IOG.

12.2 All children and young people up to the age of 18 must be referred to the CYP Principal Treatment Centre which for Kent & Medway is based at the Royal Marsden.

12.3 All young people between 16 and 24 years of age must be offered a referral to the CYP Treatment Centre.

12.4 Referral to a CYP Principal Treatment Centre does not necessarily mean that treatment will be undertaken at that Centre; shared care management protocols may allow some treatments to be undertaken locally.

12.5 The main principles in the teenage & young adult (TYA) guidance are as follows:

The 16-18 age group should be seen and treated at the TYA Principal Treatment Centre (PTC) and have their management plans discussed by the TYA PTC. Although shared care can be arranged as part of the pathway

12.6 Young people aged 19-24 years must be given choice where they would like to be treated either:

- In the TYA Principal Treatment Centre.

Or

- An adult service designated by Commissioners to treat young adults 19 to 24 years.

In both cases all young people must be given access to the services and resources offered by the TYA MDT at the PTC, this may be remotely or through specified clinical services or supportive activities, and each Trust within the TSSG will need a mechanism to identify all new TYA patients regardless of which MDT they initially present to.

13.0 Personnel and Contact Information

A comprehensive, up to date list of MDM contact details can be found on the K&M Cancer website via the following link: <http://www.kmcc.nhs.uk/resource-library/> - Terms of reference

14.0 Data Collection

14.1 Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

14.2 National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.
- Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.
- The Cancer Outcomes and Services Dataset (COSD). The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the “Core” section of the dataset, and any additional tumour site specific sections, as applicable. COSD data will be submitted according to the timetable set out by National Cancer Registration Service. Details of the COSD are available from: http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx Where applicable teams will also collect additional data items as defined in any corresponding National Clinical Audit and Patient Outcomes (NCAPOP) audit dataset. Details of these datasets are available from: <https://www.hqip.org.uk/a-z-of-nca/>. Data for NCAPOP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

14.3 Submission of data to meet these national requirements will be the responsibility of each individual Trust. Where possible and applicable, InfoFlex will be used for the collection and storage of data.

14.4 Additional areas of the COSD, relating to pathology, radiotherapy, SACT, diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

14.5 Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

14.6 Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

15.0 Key References

1. Improving Outcomes – A Strategy for Cancer. Department of Health (January 2011)
2. National Optimal Lung Cancer Pathway. NOLCP Implementation Guide. NHS England April 2018
3. [NICE NG12 diagnosis and Staging](https://www.nice.org.uk/guidance/ng122/chapter/Diagnosis-and-staging)
<https://www.nice.org.uk/guidance/ng122/chapter/Diagnosis-and-staging>

4. [Lababede O, Meziane MA. The Eighth Edition of TNM Staging of Lung Cancer: Reference Chart and Diagrams. Oncologist. 2018 Jul;23\(7\):844-848. doi: 10.1634/theoncologist.2017-0659. Epub 2018 Apr 12. PMID: 29650687; PMCID: PMC6058324.](#)
5. GIRFT Cancer Report April 2022
<https://future.nhs.uk/connect.ti/GIRFTNational/view?objectId=130557605>
6. Holistic Needs Assessment. MacMillan Cancer Support.
<https://www.macmillan.org.uk/healthcare-professionals/innovation-in-cancer-care/holistic-needs-assessment>

16.0 Glossary

Acronyms in common usage throughout K&M Cancer documentation:-

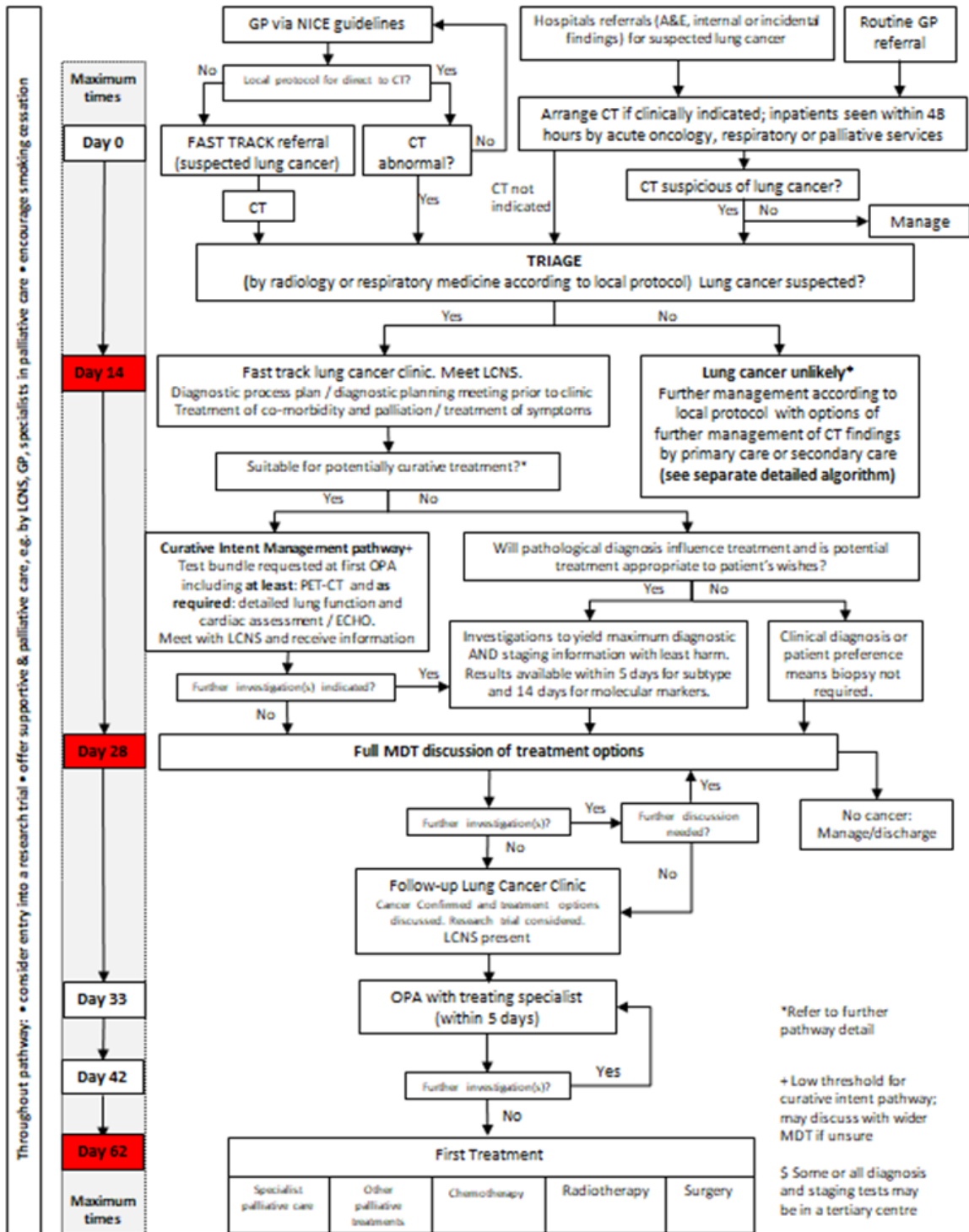
AO	Acute Oncology Service
CT	Computerised Tomogram
COSD	Cancer Outcomes & Services Data
CXR	Chest X-ray
CYP	Children & Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DVH	Dartford and Gravesham NHS Trust
EBUS	Endobronchial Ultrasound
EKHUFT	East Kent Hospitals University Foundation Trust
GP	General Practitioner
GSTT	Guy's and St. Thomas' Hospital NHS Foundation Trust
HNA	Holistic Needs Assessment
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent & Canterbury Hospital, Canterbury, (EKHUFT)
K&M	Kent & Medway
KMCC	Kent & Medway Cancer Collaborative
KMCA	Kent & Medway Cancer Alliance
LCNS	Lung Cancer Clinical Nurse Specialist
MDT	Multi-disciplinary Team for Lung Cancer
MFT	Medway Foundation Trust
MTW	Maidstone & Tunbridge Wells NHS Trust
NICE	National Institute for Health and Care Excellence
NOG	Non-Surgical Oncology Group <i>(Permanent oncologist sub group of the TSSGs with a specific responsibility for chemo/rad pathways and advice to the TSSG, K&M and geographical locations on new drugs)</i>
NOLCP	National Optimal Lung Cancer Pathway
OPD	Outpatients Department
PET	Positron Emission Tomogram
PoC	Pathway of Care

PS	Performance Status
PTC	Principal Treatment Centre
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
RAT	Research and Trial Group <i>(Permanent sub-group of the TSSGs with a specific responsibility for taking forward the clinical trials agenda)</i>
RMH	Royal Marsden NHS Foundation Trust
SACT	Systemic Anti-cancer Treatment
STT	Straight-to-Test
SVCO	Superior Vena Cava Obstruction
TSSG	Tumour Site Specific Group
TYA	Teenage and Young Adults
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
2WW	Two Week Wait
6MWT	Six Minute Walk Test

17.0 Appendix

Appendix 1: NOLCP Flowchart

National Clinical Pathway for suspected and confirmed lung cancer: Detail of referral to treatment



18.0 Document Administration

Document Title	The Management of Lung Cancer – Pathway of Care
Principle author(s)	H.Taylor/R.Shah
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Current version number	7.0
Current status	FINAL
Agreed as “Fit for Publication” by	April 2014
Original publication date	September 2005
Expected review date by	February 2025

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Revision History			
Date of revision	New Version Number	Nature of Revision	Confirmation of Accuracy by
Sept 2005	0.1	Initial draft – all sections reviewed/ new flow chart / new section on follow up	A.Jackson/D.Oliver
Dec 2005	0.2	Revised draft – revised flow diagram / revised surgical section / revised oncology section	A.Jackson/ A.Stewart / H.Taylor/ B.Cameron
Mar 2006	1.0	Published – revised oncology section	H.Taylor
Mar 2006	2.0	Published – clarification of outside referrals	A.Jackson
Jun 2008	2.1	Review draft – revised Maidstone contacts	A.Jackson
Apr 2009	2.2	Review draft – structure & content reviewed / non surgical oncology section completely updated/ surgical section updated / referral & treatment section reviewed – no change	A.Jackson/ C.Waters/ R.Shah/ H.Taylor/ K.Harrison-Phipps/ N.Goldsack
Jun 2009	3.0	Published – weblinks update & general formatting	C.Tsatsaklas/A.Jackson
Jun 2012	3.1	Draft – updated all weblinks inc. imaging, pathology & contacts; general formatting & content checking	L.Caine/S.Stanley/ C.Tsatsaklas
Sep 2012	3.2	Draft – general updates / data collection section updated	Burhan/A.Brittle/ C.Tsatsaklas
Dec 2012	4.0	Final/Published – final revisions agreed & signed off by Lung DOG meeting 13/11/12	Lung DOG/R.Shah/ I.Vousden/C.Tsatsaklas
Feb 2014	5.0	Final/Published – admin only text updated (i.e. removed	R.Shah/C.Tsatsaklas

		DOG, replaced with TSSG; removed KMCN, replaced with K&M Cancer etc) – no clinical updates made	
April 2014	5.0	Final/Published – ratified by the KMCC Operational & Quality Group	KMCC Operational & Quality Group
Oct 2019	6.0	Final/Published – final revisions agreed & signed off by Lung TSSG meeting on 17.10.19. 1.0 pg 3, 2.0 pg 4, 5.2.1 & 5.4 pg 6 & 7, 14.0 pg 12.	M. Mushtaq/A. Wiltshire
June 2022- Feb 2023	6.01 6.02	Draft – general updates and new TSSG Chair. Redesign of document in progress. Further updates during Feb 23	Tuck-Kay Loke/ A. Wiltshire
Feb 2023	7.0	Final/Published document – sign off by Lung TSSG on 30.03.23	Tuck-Kay Loke/A. Wiltshire