Lung Cancer Screening

Lung Cancer Screening – an overview

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- Where is screening available
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Lung Cancer Screening

Lung Cancer in the UK

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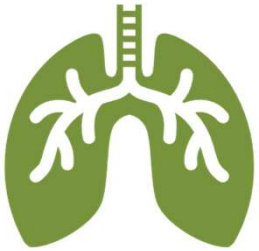
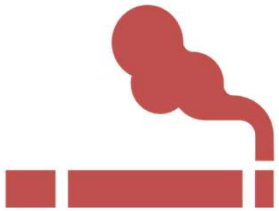


Lung cancer is the **most common** cause of cancer death in the UK

Lung cancer **caused 5% of all deaths** in Southampton in 2023



Smoking causes 72% of cases and 85% of deaths of lung cancer

Lung Cancer Screening **reduces lung cancer mortality**

- Five-year relative survival for lung cancer is generally below the European average in the UK.
- Lung cancer survival has not shown much improvement in the last 50 years in the UK.
- The UK is presented with a serious issue to tackle and screening is a successful way of preventing cancer deaths and reducing long-term complications from cancer.

Lung Cancer Screening

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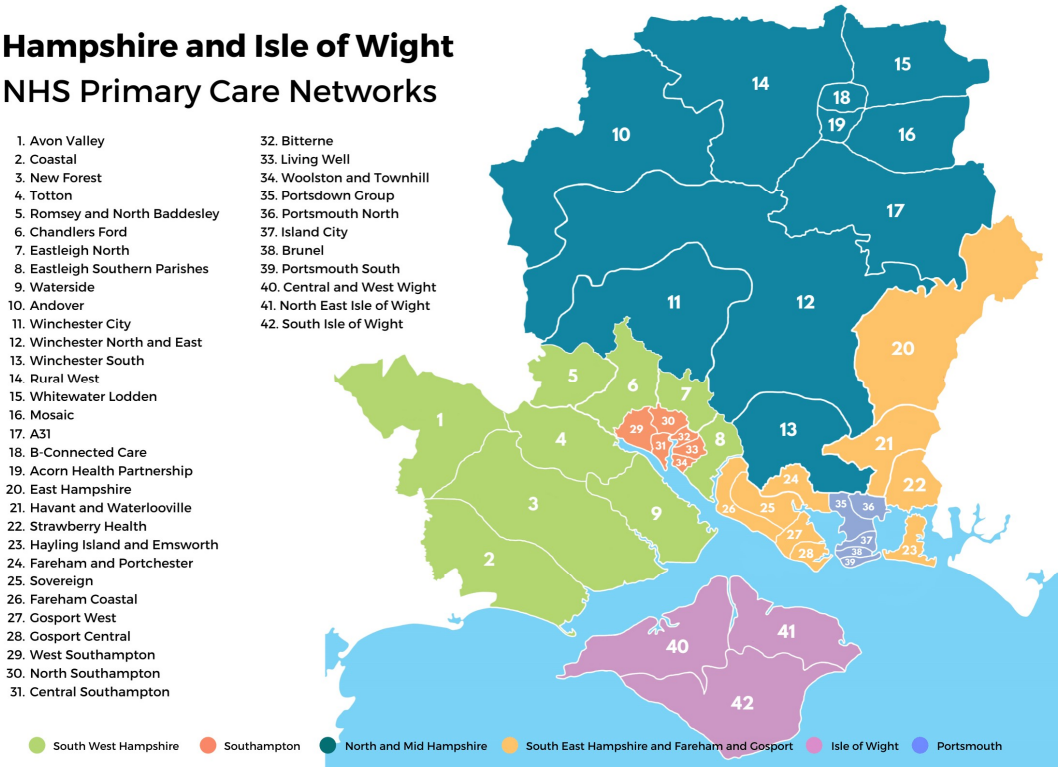
Where is screening available?

Hampshire and Isle of Wight
NHS Primary Care Networks

1. Avon Valley
2. Coastal
3. New Forest
4. Totton
5. Romsey and North Baddesley
6. Chandlers Ford
7. Eastleigh North
8. Eastleigh Southern Parishes
9. Waterside
10. Andover
11. Winchester City
12. Winchester North and East
13. Winchester South
14. Rural West
15. Whitewater Lodden
16. Mosaic
17. A31
18. B-Connected Care
19. Acorn Health Partnership
20. East Hampshire
21. Havant and Waterlooville
22. Strawberry Health
23. Hayling Island and Emsworth
24. Fareham and Portchester
25. Sovereign
26. Fareham Coastal
27. Gosport West
28. Gosport Central
29. West Southampton
30. North Southampton
31. Central Southampton
32. Bitterne
33. Living Well
34. Woolston and Townhill
35. Portsdown Group
36. Portsmouth North
37. Island City
38. Brunel
39. Portsmouth South
40. Central and West Wight
41. North East Isle of Wight
42. South Isle of Wight



<u>Established screening areas at UHS:</u>
Southampton City
Totton
Hedge End
Romsey
North Baddesley
New Forest

<u>Established screening areas across Hampshire</u>
Portsmouth (QAH)
Fareham and Gosport (QAH)
North and Mid-Hampshire (HHFT)

<u>Still to be screened</u>
East Hants
Isle of Wight

Lung Cancer Screening

The screening pathway

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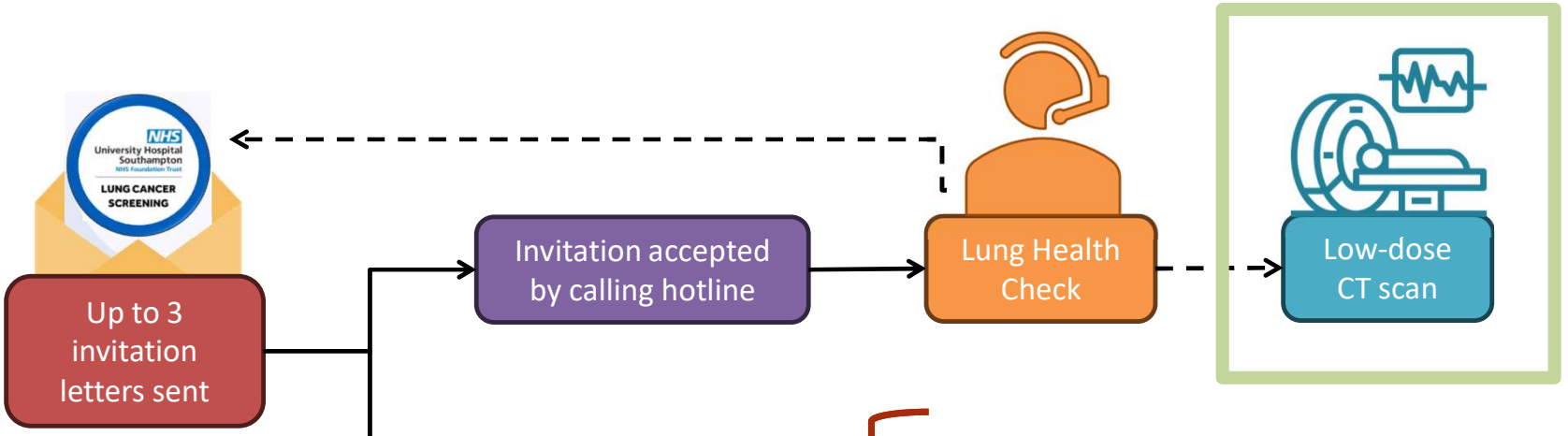

Non-responder does not access:

- Risk assessment
- Smoking cessation advice
- Further tests
- Other health advice

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The screening pathway (post-CT)

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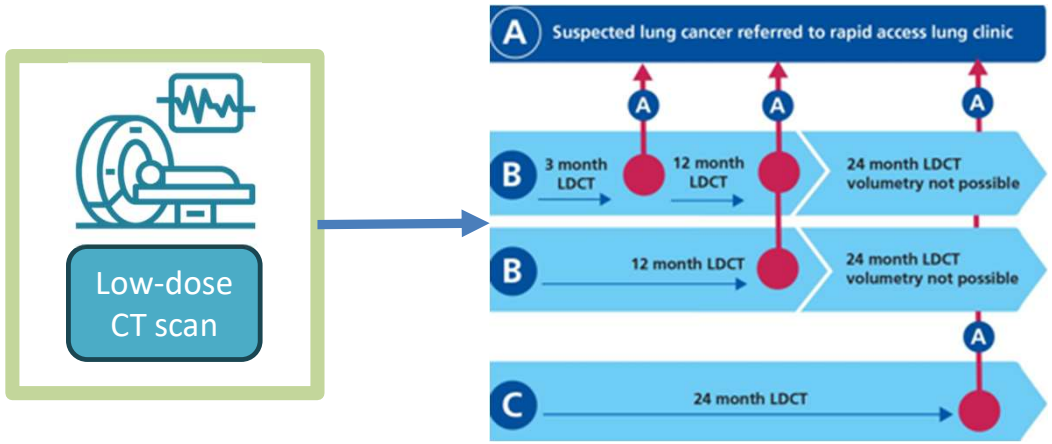

Key:

A = **suspected lung cancer** on any LDCT or ≥300mm³ or ≥8mm max. diameter and Brock risk ≥10%.

B = **indeterminate result:** B¹ ≥80 to <300mm³ or ≥6mm and <8mm.
B¹ ≥300mm³ or ≥8mm max. diameter and Brock risk <10%.
B² 5 to 6mm diameter.

C = **no significant finding** or nodule <80mm³ or <5mm max. diameter.

LDCT = low radiation dose CT.

New nodules on interval LDCT: see protocol section 5.1.2.

- The most common outcome in screening is that we find nothing leading to a routine follow-up (24 months)
- If we find something suspicious but not within the referral criteria, we will follow up within the programme
- If we find a suspected lung cancer, this will be referred on to the rapid access clinic.

Lung Cancer Screening

Standard Protocol guidance - what are we mandated to do?

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6.2.1 The Screening Review Meeting (SRM), where the management of findings (either nodules or incidental findings) requiring urgent investigation, especially those with relevant prior imaging, are discussed and management plans are devised so that communication with the participant and any healthcare professionals can be co-ordinated. • The lung cancer MDT, where the outcome of investigation of higher risk nodules and suspected lung cancer is discussed, and treatment planned.

AKA To discuss urgent findings and ensure management plans are in the patients best interest.

6.2.2 All pulmonary nodules that are indeterminate should be discussed at the LDCT review or Screening Review Meeting. These include: • nodules that are ≥300mm3 or ≥8mm diameter with a ≥10% chance of malignancy by Brock score; these usually require a PET-CT for further evaluation • nodules that show significant growth at interval LDCT. 6.2.3 Note that nodules that only require repeat CT as a further test should be managed by radiologists within the programme, and do not require discussion at MDTs (unless a second opinion is being sought, or prior imaging is available).

AKA Any indeterminate nodules need to be reviewed in MDT.

6.3.4 Incidental findings will be reviewed by the Screening Review Meeting (SRM) and clear recommendations will be made to the relevant clinicians and to the participant.

AKA Any other findings other than Lung Cancer will be discussed to ensure management plans are in the patients best interest.

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The Lung Cancer Screening MDT process

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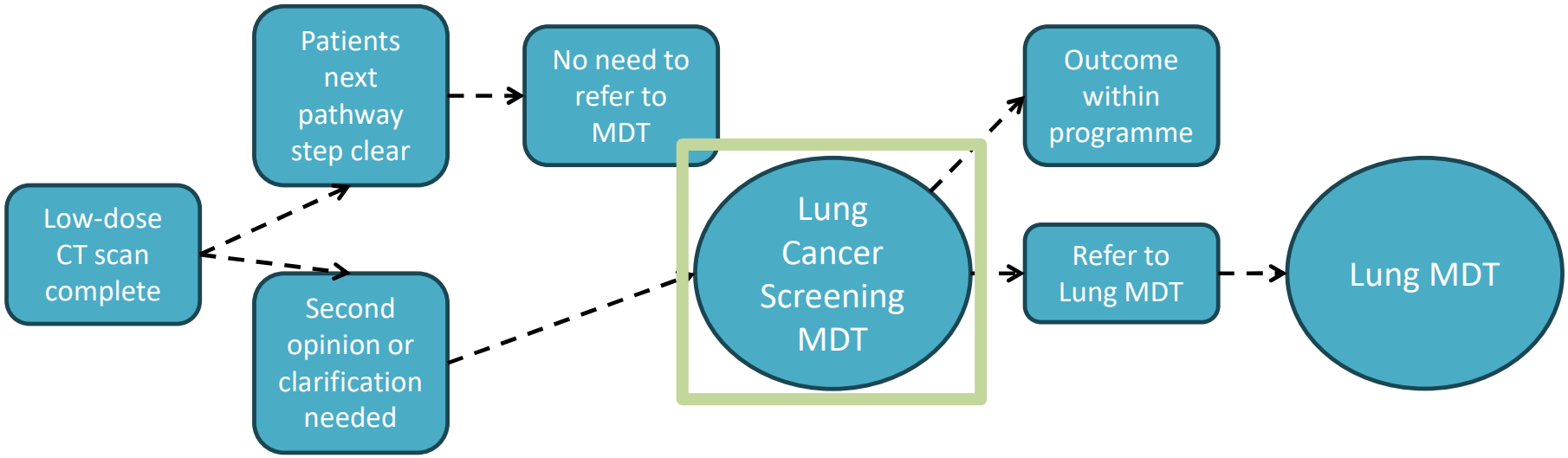

Additional points

- We also directly refer to other MDTs for things like Breast Cancer/Urological Cancers

Lung Cancer Screening

Lung Cancer Screening MDT explained

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Who can bring patients to LCS MDT

- Consultant Radiologist – *second opinion from other Radiologist or Respiratory Physician*
- Band 6 Screening Nurse – *query about eligibility or referral route, wording of letters.*
- Band 7 Responsible Assessor – *any concerning clinical features that need clarification*
- *To determine what further investigations may be necessary*

Who attends MDT?

- 2 x Consultant Cardiothoracic Radiologists
- 2 x Respiratory Physicians
- 1 x MDT Coordinator
- 1 x Responsible Assessor/Band 6 Screening Nurse
- Optional attendance from Responsible Clinician, Clinical Lead and Responsible Radiologist

Why are patients referred to LCS MDT?

- Query over the correct pathway for the patient
- Query over eligibility to take part in the programme
- Complex respiratory history
- Confirm correct referral route
- Shared knowledge on the optimal referral route

Lung Cancer Screening

What system do we use? TARLUN

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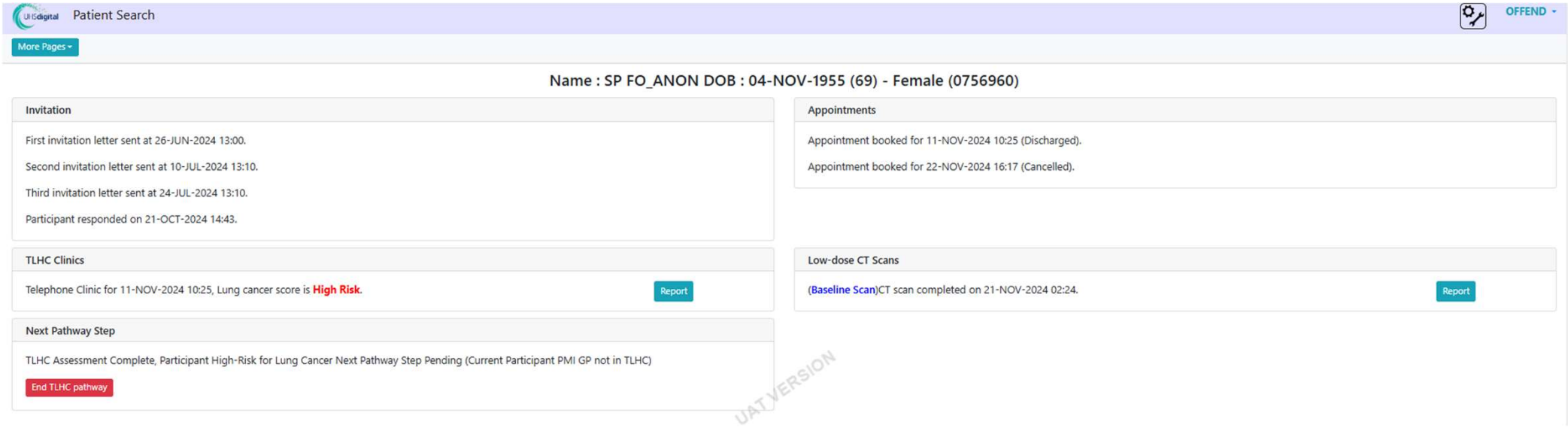
What is TARLUN?

TARLUN is integral to the running of the Lung Cancer Screening service at UHS. It is a central patient administration system that is used by all staff that interact with the screening service from Band 2 Administrators to Radiographers, Radiologists and Respiratory Consultants.

TARLUN tracks the patient throughout the whole of the participant pathway from sending invite letters to participants, completing the Lung Health Check Assessment, to completing the CT report and outcomes, and sending pre-populated letter templates at the touch of a button.



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Routes in and out of the LCS Programme

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Into the programme

- Invited into the programme via letter.
- Self-referral by calling the LCS contact number.
- Previously referred to Lung Cancer Services and discharged from them.

Out of the programme

- Aged out of the LCS Programme aged 75.
- Referred to Lung Cancer Services.
- Move out of the screening catchment area.
- Referred to Pulmonary Nodule Surveillance service if over the age of 74 and needing follow-up for a ground glass nodule.

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Incidental findings

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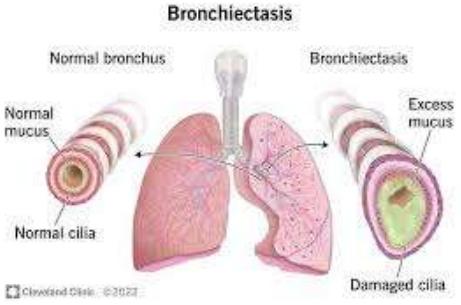
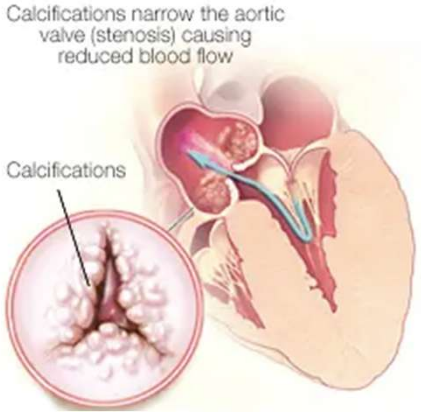
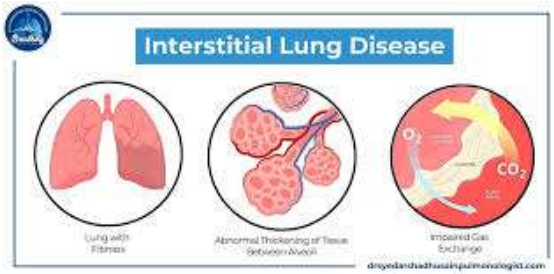
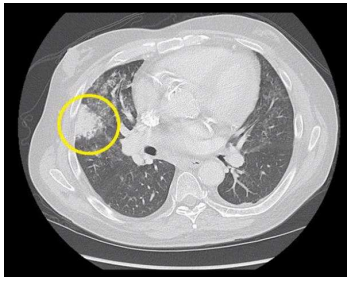




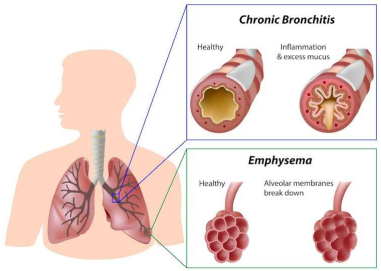
AV calcification

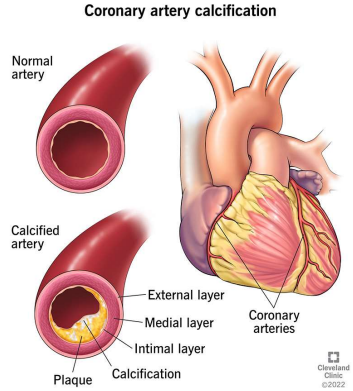




Inflammatory consolidation

Chronic Obstructive Pulmonary Disease (COPD)





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Findings that may be referred to other MDTs!

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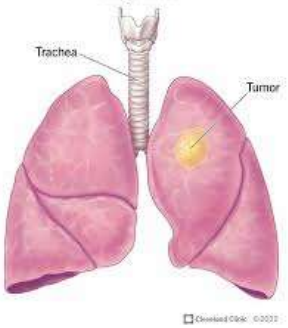
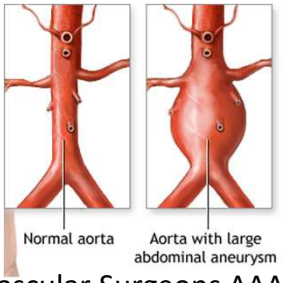
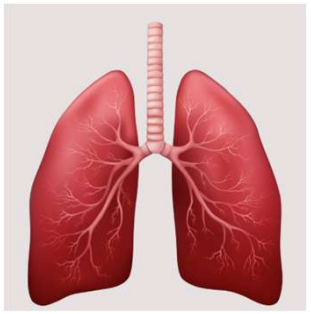
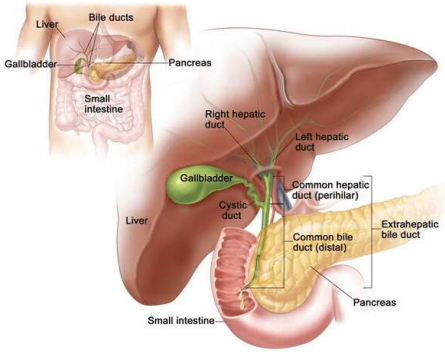




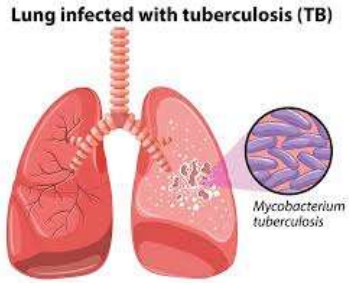
Vascular Surgeons AAA

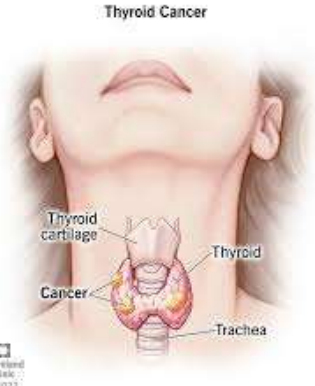


Gen Resp



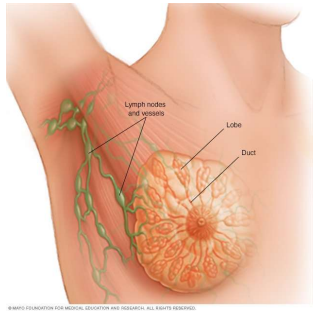
HPB





Thyroid/ENT/Head & Neck

Renal



Breast

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Any questions?