Lung Cancer and the Cancer Alliance

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Background

Lung cancer is the second commonest cancer in the UK (37,000 new cases in England each year).

Commonest cause of cancer death (28,500 people die annually from the disease).

Whilst survival rates have improved for many cancers, lung cancer survival rates remain low
- < 30% 1 year survival
- 10% 5 year survival

Lower than European benchmark.

Earlier diagnosis improves lung cancer survival – more than 1/3 patients diagnosed with early stage disease are alive after 5 years.
Poor outcome is linked to the stage of presentation
What factors contribute to poor outcome?

Late diagnosis.

Variation in delivery of care across the country (unacceptable).

Discrepancies in stage-specific survival suggest other factors are important, including differences in treatment.
Late Diagnosis

Patient factors

Service delivery factors
Patient factors

2/3 of physicians believed that greater public awareness of symptoms of lung cancer is likely to have a significant impact on the outcomes for patients.

Multiple public health campaigns have increase awareness and promote earlier attendances with relevant symptoms to primary care.

Despite this, symptoms are often present for several months prior to patients seeking medical advice.

Only 5% of the UK public recall persistent cough as a lung cancer symptom.

Symptoms are often not thought to be serious.

There is genuine fear.
Identification and referral

The first identification and referral of patients with suspected lung cancer is dependent on primary care.

Rapid recognition, risk assessment and referral are crucial to reduce delays in diagnosis.

Survey of respiratory physicians – respondents thought that these would be opportunities to make a diagnosis significantly earlier in 1/3 patients.

Successful referral through out patient pathways reduces the high numbers of patients who present through emergency pathways.

Early detection allows the best chance of cure.

Nihilism still exists regarding treatment options and impacts on referral practice.
Service Design

The National Lung Cancer Audit reports wide and unacceptable variation in standards of care and survival between health care organisations in England.

Local data suggests a similar pattern at a regional level and even across the STP.

Studies demonstrate untimely delays from presentation to diagnosis – up to 4 months from 1st presentation to primary care.

Compliance against performance measures is usually strong – when does the clock start?

For lung cancer, the diagnostic pathway is complex; there is usually sequential ordering of tests and delays can occur at every stage in the process.
Our aim is to:

Audit the patients diagnosed with lung cancer through emergency pathways, to identify areas of learning/missed opportunities.

Address unacceptable variation by standardising the diagnostic pathway

Lung cancer has been prioritised as one of the key cancer sites requiring investment in the East of England.

Objectives:

◦ Increase stage 1 and 2 diagnoses.
◦ Decrease the proportion of diagnoses in emergency settings.
Audit 2012

To compare lung cancer outcomes between primary care referrals and emergency presentations. Reviewed 2010 LUCADA dataset.

63/144 primary care / out patient referrals (43.75%). Compared PS, stage at presentation and treatments offered.

In patients had worse PS, more advanced stage at presentation and reduced survival. Patients referred via out patients had better outcomes.

Those patients presenting directly to A&E highlighted possibility of being “missed” in primary care.
CADIAS

The study looking at cancer diagnosis in the acute setting (CADIAS) aimed to explain why 39% of patients with lung cancer presented as an emergency.

Nearly half of the patients reported that something had put them off going to the doctor.

- Difficulty making an appointment
- Not being able to see their usual doctor
- Not having confidence in the G.P.
- Fear of what the doctor might find
- 18% of patients said that they had not realised their symptoms were serious

A fifth of all patients delayed going to their doctor with their symptoms for more than 12 weeks (typically older and more fearful of what the doctor might find).
Current Luton data


83 patients presented through the emergency pathway (46.9%).

94 patients presented through OP/2WW/C2C (53.1%)

70 of the 83 patients presenting through the emergency pathway RIP (84%).

57 of the 94 patients presenting through OP pathways RIP (60%).
Significant event audit

Method of reflecting and learning from individual cases to improve quality of care.

The SEA augments reflective practice and encourages the clinician to deconstruct the pathway to diagnosis and disentangle themes that can lead to a range of improvements.

What happened and why?
What was the impact on those involved?
How could things have been different?
What can we learn from what happened?
What needs to change?
Results

Only 18 out of 83 cases were available at the time of the review.

15 are white British.

10 are male.

8 are female.

Analysis was grouped into three different types of cases:

 ◦ Those where it would not have been possible to change the route to diagnosis or the outcome.
 ◦ Those where an earlier and different route to diagnosis could have been possible, but where the prognosis was likely to have been the same, however the patient’s experience may have been improved.
 ◦ Those where missed opportunities for an earlier diagnosis and potentially better prognosis were identified.
Results continued

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<thead>
<tr>
<th>No change</th>
<th>Different route but prognosis would not change</th>
<th>Missed opportunity</th>
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<td>10</td>
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Conclusions

Not all emergency presentations of lung cancer can be prevented,

The findings of this project identified some cases where it may have been possible to establish diagnosis earlier.

Earlier diagnosis of cancer and avoidance of emergency presentation could contribute to a less traumatic experience for the patient and their family, even where the overall prognosis is poor.

A number of factors can contribute to the likelihood of lung cancer being diagnosed via an emergency pathway.

Some factors may be modifiable by changes in professional practice, but it is vital that patients are also fully engaged.

Lack of understanding or apparent limited knowledge of NICE referral guidelines.
NICE referral guidelines

When should I refer a person with suspected lung cancer?

Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for lung cancer if they:

Have chest X-ray findings that suggest lung cancer or

Are aged 40 and over with unexplained haemoptysis (new NICE recommendation for 2015).
NICE referral guidelines

Offer an urgent chest X ray (to be performed within 2 weeks) to assess for lung cancer in people aged 40 and over if they have two or more of the following unexplained symptoms, or if they have ever smoked and have 1 or more of the following unexplained symptoms:

- Cough
- Fatigue
- Shortness of breath
- Chest pain
- Weight loss
- Appetite loss (new NICE recommendation for 2015)
NICE referral guidelines

Consider an urgent chest X-ray (to be performed within 2 weeks) to assess for lung cancer in people aged 40 and over with any of the following:

- Persistent or recurrent chest infection.
- Finger clubbing.
- Supraclavicular lymphadenopathy or persistent cervical lymphadenopathy.
- Chest signs consistent with lung cancer.
- Thrombocytosis (new NICE recommendation for 2015)
Addressing unacceptable variation

Implementation of the optimal lung pathway.

Direct access to chest x-ray.

Hot reporting of chest x-rays.

Escalation to CT within 72 hours.

Anticipated diagnostic tests are frontloaded and, where possible, bundled to shorten the diagnostic phase of the pathway.

Diagnostic requesting is correctly prioritised.

Eradication of MDT paralysis. Opportunities for urgent planning decisions are enabled between MDTs.
The optimal lung pathway
What next?

Natural history of lung cancer and difficulties encountered across the diagnostic pathway facilitate late presentation and poor patient outcomes.

A national screening programme is likely to be the only solution.
Thank you