

# ACE: Lung Cancer Pathways

## 'Straight to CT' quick reference guide

### Context

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A chest x-ray (CXR) is likely to be the first test offered to a patient with symptoms that may indicate a lung problem or lung cancer. If the CXR shows an abnormality that could indicate cancer, then it is important that quick action is taken to confirm or rule out cancer.

Patients with abnormal CXR results are more likely to have cancer than those with normal CXR results, so their pathway needs to be at least as quick as patients that have been referred via a two week wait (2WW) referral.

### Range of current practice

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A recent ACE survey has found that there is considerable variation across NHS trusts in terms of what happens when an abnormal CXR result is detected. Key differences in current practice relate to:

- Who is responsible for the next step e.g. GP, radiologist, physician or cancer team
- What, if any, safety net arrangements are in place
- Communications with the patient – when and by whom is this done
- How the cancer pathway is triggered, whether by 2WW or consultant upgrade
- When the cancer pathway is triggered i.e. following an abnormal CXR result or an abnormal CT result

#### **Traditional/historical pathway**

- GP refers patient for a CXR
- CXR report produced and sent back to GP
- GP reads the report decides on next step

#### **Risks involved in traditional pathway**

- CXR report may be unclear so GP doesn't make 2WW referral
- Lack of safety net in place so patient gets 'lost' to system
- Patient not aware a CT might be needed, so there is delay for extra discussion

#### **A 'straight to CT' pathway**

- GP refers patient for a CXR, having explained to them that a further test i.e. a CT may also be required and if so, the hospital will contact them directly to arrange this
- Radiologist/radiographer spots a potential cancer on CXR and either arranges a CT directly or puts ALERT on report
- ALERT code triggers notification to cancer team with cc to GP
- Referral checked to confirm that a CT is appropriate

➤ Patient contacted by secondary care and CT scan booked for earliest possible date  
The phrase '**direct access to CT**', generally refers to a pathway where GPs refer a patient directly for a CT test and outside of a 2WW pathway. This can provide an alternative to using a 2WW pathway for lower risk patients and is available in some localities.

#### **How and when does the cancer pathway start?**

- In some localities, GPs are asked to make a 2WW referral, when an abnormal CXR is identified in order to start the 2WW/62 day clock
- In other localities, the radiologist or lung physician will use the consultant upgrade mechanism to put the patient onto a cancer pathway
- Both of these arrangements are acceptable and allowable under Cancer Waiting Times (CWT) guidance

#### **Discharging patients from the cancer pathway**

- Within CWT guidance, the CT scan can stop the 2WW clock
- If a CT scan is clear following a straight-to-CT arrangement, and the result is sufficient to reassure the physician, a patient can be discharged without needing an outpatient appointment (OPA)
- The discharge can be to a respiratory clinic or back to the GP depending on what is most appropriate, but there is no requirement for the patient to have an OPA, even if they were originally referred in as a 2WW referral

### Important considerations

**Clarity and coordination** – All relevant primary and secondary care clinicians need to agree how they want this pathway to work and ensure it is followed. Lapses should be followed up quickly to prevent confusion and to reinforce expectations.

**Good patient communication** - If patients know that a CT might be needed, the test can be more easily arranged and will cause less stress. Information leaflets are useful too.

**ALERT code**, – Useful to ensure all key players are notified as quickly as possible when cancer suspected. Ensure notification system has no room for error.

**Safety net** – If local arrangements require the GP to make a 2WW referral to trigger process, then cancer team needs to be ready to chase if referral not received promptly.

**Speed, but not haste** - Agree a realistic but appropriate target for completing CTs following abnormal CXR. Then monitor and discuss reasons for lapses. Optimal is within 72 hours.

**Chest x-ray referral forms** – These need to include all relevant clinical information and explain why the CXR is being requested. See section 9, ACE Lung Pathways final report.

**Reporting CXR results** – Reporting CXRs and producing reports with clear, consistent advice is best undertaken by a small pool of trained/experienced radiologists and/or reporting radiographers, with each perhaps reporting a minimum of 2,000 CXRs pa.

**Structured/coded CXR reporting system** – This will help radiologists to communicate the CXR results more clearly and ensure a recommended action is included. See BSUH example in ACE Lung Pathways final report.

**Commissioning implications** – It is important that commissioners are part of the planning process and that planned changes are addressed fully in commissioning arrangements.

### Radiology perspective

Local protocols should be in place for a straight-to-CT pathway. IR(ME)R regulations require that there is an appropriate process in place for referral and justification. In this pathway, the referrer is the GP who is requesting, as per agreed pathways, a CXR +/- CT thorax. Royal College of Radiologists guidance states that “...many radiology departments will accept referrals from outside their own organisation for example a general practitioner. In this situation, the employer’s procedures must state from whom they will accept referrals and how the referrer will be provided with referral criteria”.

The radiologist reporting the CXR in this scenario is requesting, justifying and authorizing the CT. In centres where radiographers report CXRs, a radiologist would usually review the film and radiographer report and action the CT referral.

### The outpatient appointment (OPA)

Some trusts include an OPA before the CT after an abnormal CXR result is identified, but if clinical information is provided in the referral and the patient has been told that a CT might be needed, there should be no need for an outpatient appointment prior to the CT (unless part of a same day clinic arrangement), and this extra step could add delay.

Good communication with patients is key and it is important that responsibility for this, particularly when a straight to CT arrangement is being implemented, is discussed and agreed locally. Using a secondary care OPA for this purpose is an expensive option and may require the patient to make an additional journey to hospital.

### Potential impact on pathway

The ACE projects that implemented straight to CT arrangements all achieved shorter cancer pathways as a result of the implementation. Consistent pathway reductions of 12 days, and 13 days were achieved by two ACE projects and for a third project, there was a 20 day difference between their poorest performance timings to their peak performance post

implementation of Straight-to-CT. Please see Section 4 of the ACE Lung Pathways final report for more information on these three ACE projects.

For more information please contact the ACE Programme at [ACEteam@cancer.org.uk](mailto:ACEteam@cancer.org.uk)