West of Scotland Cancer Network

Lung Cancer
Managed Clinical Network

Lung Cancer

Regional Follow-up Guidance

Prepared by	Michael Sproule, Joris Van der Horst, Nazia Mohammed, Noelle O'Rourke, Agnes MacKay, John Maclay
Approved by	Lung Cancer MCN Advisory Board/Regional Cancer Clinical Leads Group/Regional Cancer Advisory Group
Issue date	April 2021
Review date	April 2024
Version	V2.0

Lung Cancer Regional Follow-up Guidance Review

The purpose of the lung cancer regional follow-up guidance is to ensure consistency of practice across the West of Scotland and the principles of any revision to the follow-up guidance will continue to ensure that management of patients after initial treatment for lung cancer are:

- Patient-centred;
- Aligned to recognised current best practice;
- Equitable across the region;
- Clinically safe and effective; and
- Efficiently delivered.

The guidance continues to be developed on the basis that the key aims underpinning the purpose of follow-up are to:

- Manage and treat symptoms and complications;
- Provide psychological and supportive care; and
- Detect and treat new and recurrent disease.

It is recommended that all patients receiving treatment for lung cancer should undergo a holistic needs assessment (HNA) by a suitably trained individual at defined time points during follow up care.

A review of lung cancer guidance published since issue of the Version 1 of the follow up guidance in 2015 was undertaken in November 2019. The evidence review concluded that there is a paucity of high quality data assessing the optimal imaging surveillance strategy in patients with lung cancer.

The available surveillance schedules are based on weak or moderate evidence for efficacy, and with limited clinical benefit. Nonetheless, given the significant likelihood of developing recurrent disease or a metachronous tumour, most national and international oncology societies have generated guideline statements that include recommendations for post treatment surveillance imaging.

This guideline includes imaging recommendations for the following scenarios:

- All NSCLC patients treated with radical intent,
- All other patients,
- Immunotherapy,
- Brain imaging
- Small Cell Lung Cancer (SCLC)

Future Developments:

Recent studies[1] have provided evidence for cost effectiveness and significantly improved median survival using web-mediated symptom based weekly self-assessment scores to guide earlier imaging for higher stage lung cancer patients following or during treatment. Consideration should be given to piloting / setting up a similar follow up regime, perhaps adapting it to deprived populations with low internet access (SMS, automated phone call system).

Lung Cancer MCN Follow Up Guidelines (Imaging)

All patients with Non-Small Cell Lung Cancer (NSCLC) treated with radical intent (surgery, radical chemo/radiotherapy and SABR) and all patients treated with high dose palliative radiotherapy

There is a key question to be addressed when considering the imaging follow up regimen.

- **Is salvage treatment still an option?**
  (Decision based on patient preference, comorbidities, performance status, nature and location of tumour and available treatment options).
    a. If yes: continue imaging FU,
    b. If no: symptom based FU with imaging as required to guide local palliative treatment.

At every clinic visit/ contact the issue of suitability for further treatment must be reviewed. If the patient is no longer suitable for salvage treatment (Surgery, Radical RT, HDPT, SACT) then routine imaging surveillance should not be continued.

Recommendations

- Stage I disease (T1a-c, T2a N0 i.e. tumour <4cm and N0): annual non-contrast CT of the thorax for 5 years.
- Stage IIA and greater (T2b N0 and above ie tumour >4cm and N0 or Any T and any thoracic nodes N1 or above): 6 monthly contrast CT chest/abdomen at 6, 12, 18 and 24 months, followed by annual non-contrast CT of the thorax for the next 3 years.

All other patients

Recommendation

- Clinical/symptomatic review +/- imaging (CT+/- PET-CT may be appropriate **if salvage treatment an option**)

Immunotherapy/Targeted Therapy

Frequently these patients have more advanced disease and limited salvage options.

Recommendation

- Imaging follow up at the discretion of the treating oncologist. Less, rather than more imaging is to be aspired to. Therefore avoid a simple continuation of the “trial imaging protocol”.

Brain Imaging

Recommendations

- Routine brain imaging is not indicated (i.e., at the time of the 6 monthly or annual CT of the thorax).
- Brain imaging is indicated:
    1. If there is recurrent disease on the FU CT, and salvage treatment is being considered.
    2. If there are clinical features of brain metastases.

Small Cell Lung Cancer (SCLC)[2]

Recommendations

- Patients with localised disease who have had potentially curative treatment should be followed up with the same protocol as patients with non small cell cancer treated with radical intent.
- Patients with metastatic disease who potentially qualify for second treatment should have 2-3 monthly IV contrast enhanced CT scans of the thorax and abdomen.

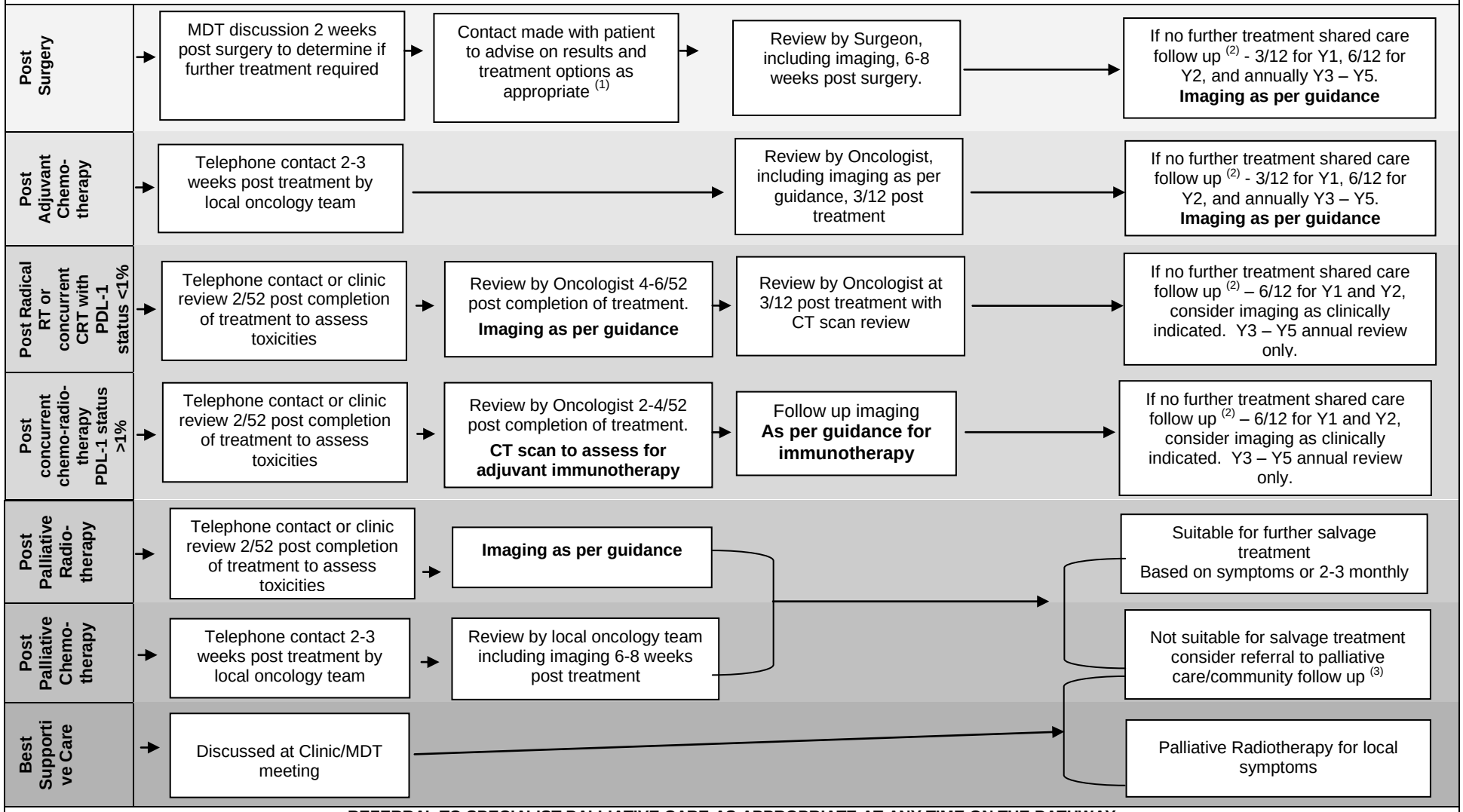
References:

[1] *F Denis et al JNCI J Natl Cancer Inst (2017) 109(9): djx029*

[2] *Früh M, De Ruysscher D, Popat S, et al. Small-cell lung cancer (SCLC): ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol. 2013;24 Suppl 6:vi99-vi105. doi:10.1093/annonc/mdt178*

Appendix 1: Optimal Follow up Schedule

At the end of initial treatment, communication should be sent to the local CNS, Respiratory Physician, Patient, and GP, in treatment summary format if available.
Details of the follow up pathway appropriate to the patients' treatment, as below, should be discussed with the patient.



REFERRAL TO SPECIALIST PALLIATIVE CARE AS APPROPRIATE AT ANY TIME ON THE PATHWAY

RAPID REFERRAL ROUTE BACK TO ACTIVE TREATMENT IS AVAILABLE AT ALL TIMES

PATIENTS SHOULD BE REFERRED BACK TO MDT FOR DISCUSSION AS APPROPRIATE

DISCHARGE AT END OF Y5 FOR ALL PATIENTS

(1) Adjuvant treatment should start between 6-8 weeks (chemotherapy).
(2) Decision on who follows up in a shared care approach made locally between oncology and respiratory teams; consider a nurse-led clinic in parallel with a consultant-led clinic. Rapid referral route back to active treatment should be in place.
(3) Contact made with patient unless declined by patient. Decision on contact made local, options: Attendance at clinic, CNS telephone contact/Palliative Care Team/ community palliative care/GP/Shared care model