West of Scotland Lung Cancer Webinar FAQs

Why is lung cancer more common in over 40s?

- It takes time to develop lung cancer, approximately 5-10 years
- For every 3 cigarettes smoked, you develop a mutation
- You need 5 or 6 mutations of a certain type in combination to create the code for cancer
- Some patients start off at a genetic disadvantage, already having one or two faulty genes or lacking protective genes
- These individuals have an increased risk as it takes fewer mutations to form the combination of genes needed to get cancer started

So, what advise should we give so someone who has a family history of lung cancer?

They may be at increased risk and thus should be advised to stay away from cigarettes as a precaution.

Who is responsible for nodule follow up from GP requested CT scans?

- Clinicians will always retain responsibility for acting on the investigations they order. However, once a lung nodule is detected these can be referred on to respiratory team for further assessment and follow-up
- The radiologist reporting the scan would ideally have flagged this to the respiratory team, but this is not guaranteed
- Even if this nodule turns out to be a metastasis from another site, the respiratory team have the all the tools at their fingertips to promptly and appropriately investigate
- While the GP should inform the patient they are being referred, the patient will also receive communication from the respiratory team explaining any follow up investigations required

Are any other health boards doing similar work enhancing and streamlining their lung cancer referral pathways?

In many areas there are similar initiatives with varying outcomes. In our region we hope to extend the pathway beyond Glasgow to cover the whole of the West of Scotland.

Is it a good idea to opportunistically ask about lung cancer red flag symptoms during patient contact for things like smoking cessation?

- This is an ideal opportunity to screen for the red flag symptoms
- Pilots have been done in primary care settings in Scotland already
- Other opportunities include patient medication reviews and chronic disease reviews
- Looking to the future, the next step will be formal lung health check sessions comprising spirometry, smoking cessation advice, screening questions and a chest x-ray if deemed appropriate across the multidisciplinary team

I'm worried about interpreting and actioning the results of GP requested CT scans. How are we going to do this safely?

- The radiologists now have standardised reporting templates with a very clear explanation both of findings and what action is required
- If there is a positive finding which requires further action this should then be referred on directly to the appropriate specialty in secondary care
- A lung nodule should be referred to respiratory and a suspicious adrenal lesion should go to endocrinology. If no action on an "incidentaloma" is needed, the report should say this
- It is important to communicate any referrals to the patient at a primary care level

What are the take home messages from our session panellists?

Lisa Cohen (Cancer Research):

Time is of the essence. Community pharmacy are a key player.

Dr Douglas Rigg (GP):

Cough isn't always COVID-19. This includes patients with chronic respiratory conditions which are worsening. Let's establish communication pathways with community pharmacy.

Dr Joris Van der Horst (Respiratory medicine)

Have a low threshold for doing a chest x-ray and referring patients to us. We have capacity and are open for business!

Amanda Rae (Community pharmacy)

Let's work together to develop simple, and efficient communication routes between community pharmacy and primary care teams