

# Investigating symptoms of lung cancer: a guide for GPs

This guide was developed to assist GPs to manage people who have or may have lung cancer and support the **early and rapid referral** into the cancer care pathway. This is a general guide to appropriate practice to be followed subject to the clinician's judgement in each individual case. The guide is based on the best available evidence and expert consensus. August 2012.



The Royal Australian  
College of General  
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Australian Government  
Cancer Australia

**Lung cancer is the most common cause of cancer death in Australia. Symptoms of lung cancer can often be non-specific thereby hindering early diagnosis and treatment.**

## Lung cancer in Australia<sup>1</sup>

- Lung cancer is the fourth most commonly diagnosed invasive cancer in Australia. Around 6000 men and 3800 women were diagnosed with lung cancer in Australia in 2007.
- Lung cancer is the leading cause of cancer death, for both non-Indigenous and Indigenous men and women.
- Only 14% of those diagnosed with lung cancer survive five years after diagnosis.<sup>2</sup>
- The incidence of lung cancer is strongly related to age, with over 80% of new lung cancers diagnosed in people aged 60 years and older.
- While tobacco smoking is the largest single cause of lung cancer, people who have never smoked may also be diagnosed with lung cancer.<sup>3</sup> About 90% of lung cancer in males and 65% in females is estimated to be a result of tobacco smoking.
- Indigenous people are about 1.7 times as likely to be diagnosed with lung cancer as non-Indigenous people. This difference may be partly explained by higher rates of smoking by Indigenous adults.

## Risk factors for lung cancer<sup>1</sup>

### Lifestyle factors:

- Tobacco smoking\*

### Environmental factors:

- Passive smoking
- Radon exposure
- Occupational exposure e.g. asbestos, diesel exhaust<sup>4</sup>
- Air pollution

### Personal factors:

- Age
- Family history of lung cancer
- Previous lung diseases

### \*Differences in smoking rates may occur by:

- Geographical area
- Socio-economic status
- Aboriginal and Torres Strait Islander status
- Country of birth

## Recommendations to facilitate referral and patient support

- Ensure referrals are timely and provide relevant and sufficiently detailed information to the specialist
- Provide the patient with information that clearly describes:
  - where the patient is being referred
  - who the patient will see (for example, which specialist)
  - what the patient can expect from the specialty service
  - the expected timeframes.
- Advise the patient to carry their previous imaging results when they attend a new chest X-ray or chest CT scan.
- Advise the patient to stop smoking, and offer nicotine replacement therapy and/or other therapies to assist the patient to stop smoking.
- Ensure the patient's need for continuing support is addressed whilst they are waiting for their referral appointment. Where possible, provide culturally-appropriate information and support.
- Share information between healthcare professionals about:
  - the management plan
  - what the patient has been told
  - what the patient has understood (where possible)
  - the involvement of other healthcare professionals
  - any advance decision made by the patient with regard to end-of-life care
  - other relevant patient information.

## The role of multidisciplinary teams in early diagnosis and patient care

### Multidisciplinary care is the best practice approach to providing evidence-based cancer care.

The GP's role is vital in the early and rapid referral of patients with suspected lung cancer to lung cancer multidisciplinary teams (MDTs).

Aboriginal Health Workers provide a critical link for Aboriginal and Torres Strait Islander people with cancer in providing information, support and co-ordination to improve health outcomes.

Multidisciplinary care (MDC) is an integrated team-based approach to cancer care where medical and allied health care professionals consider all relevant treatment options and collaboratively develop an individual treatment and care plan for each patient.<sup>5</sup>

Evidence indicates that a team approach to cancer care can improve patient survival and quality of life, improve delivery of best practice care in accord with evidence-based guidelines, improve coordination of care, and facilitate the provision of information and support for patients.<sup>6,7</sup>

In lung cancer, a small number of available studies have found improved survival of patients<sup>8,9</sup> who had been diagnosed via an MDT.<sup>10,11,12</sup> MDC has also been associated with improved patient satisfaction, increased rates of surgical resection, radical radiotherapy, chemotherapy and timeliness of care.<sup>13</sup>

The existence of lung cancer MDTs across Australia provide the mechanism to improve patient care, outcomes and address variations in care.

**References** 1. AIHW & Cancer Australia 2011. Lung cancer in Australia: an overview. Cat. No. CAN 58. Canberra: AIHW. 2. AIHW 2012. Cancer survival and prevalence in Australia: period estimates from 1982 to 2010. Cat. No. CAN 65. Canberra: AIHW. 3. Hippisley-Cox J, Coupland C. Br J Gen Pract. 2011 November; 61(592): e715–e723. 4. Benbrahim-Tallaa L, Baan R et al Lancet Oncol 2012 July; 13(7):663-644 5. NBOCC. Multidisciplinary Care in Australia: A National Demonstration Project in Breast Cancer. NBOCC. Camperdown, NSW 2003. 6. Wilcoxon H, Luxford K, Saunders C, Peterson J & Zorbas H. Asia Pac J Clin Oncol 2011;7:34-40. 7. Saini KS, Taylor C, Ramirez AJ, Palmieri C, et al. Ann Oncol 2012;23(4):853-9. 8. Price A, Kerr G, Gregor G, Ironside J, Little F. Radiother Oncol 2002;64 (Suppl. 1):80. 9. Forrest LM, McMillan DC, McArdle CS, Dunlop DJ. Br J Cancer 2005;93:977-78. 10. Murray PV, O'Brien ME, Sayer R, et al. Lung Cancer 2003;42(3):283-90. 11. Martin-Ucar AE, Waller DA, Atkins JL, et al. Lung Cancer 2004;46:227-32. 12. Dillman RO, Chico SD. J Oncol Pract 2005;1:84-92. 13. Coory M, Gkolia P, Yang IA, Bowman RV, Fong KM. Lung Cancer 2008;60(1):14-21.

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## Symptoms and signs

Unexplained haemoptysis

or

Any of the following **unexplained, persistent symptoms and signs** lasting more than 3 weeks (or less than 3 weeks in people with known risk factors):

- New or changed cough
- Chest and/or shoulder pain
- Shortness of breath
- Hoarseness
- Weight loss/ loss of appetite
- Unresolved chest infection
- Abnormal chest signs
- Finger clubbing
- Cervical and/or supraclavicular lymphadenopathy
- Features suggestive of metastasis from a lung cancer (e.g. in brain, bone, liver or skin)
- Signs of pleural effusion

- Persistent haemoptysis
- Signs of superior vena caval obstruction

- **Massive haemoptysis**
- **Stridor**

### Urgent referral

### Chest X-ray

Chest X-ray normal

Consolidation consistent with the clinical picture

Pulmonary nodule(s) visible

Chest X-ray normal, but there is a high clinical suspicion of lung cancer

Chest X-ray suggests lung cancer

Monitor for persistent symptoms

Treat accordingly

Review previous chest X-rays and other imaging tests

Urgent referral

Immediate referral

Urgent referral to a specialist linked to a lung cancer multidisciplinary team and **concurrent chest CT scan**

Repeat chest X-ray within 6 weeks

No change visible

Change visible, or no previous imaging available

Persistent consolidation

Monitor for persistent symptoms

### Chest CT scan

Chest CT scan normal

Abnormal or non-specific findings

Pulmonary nodule(s) visible

Chest CT scan suggests lung cancer

Monitor for persistent symptoms

Review previous chest CT scans

Urgent referral to a specialist linked to a lung cancer multidisciplinary team (consider immediate telephone contact)

Immediate referral to Emergency Department

Referral to a respiratory physician or a specialist with expertise in lung disease

No change visible

Change visible, or no previous imaging available