

Organizing the care of lung cancer patients

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For years lung cancer has been the Cinderella of malignant disease, perceived as being self-inflicted and incurable. The government has put cancer management high on its agenda and is setting targets for clinicians to aim at. This article looks at the changes which are occurring in the way lung cancer is managed.

Lung cancer is the commonest cause of fatal malignancy in the western world. In the UK the prognosis for patients diagnosed with the condition has not changed in decades, with 5-year survival rates of less than 10%. Lung cancer patients are usually elderly, tend to come from poorer socioeconomic groups and have a lot of comorbid illness, usually related to cigarette smoking. In the past little was known about the way this condition was managed. Surgery and radical radiotherapy remain the only treatments associated with improved survival, but are available to only a small proportion of patients. The vast majority of sufferers live for a matter of months and any treatment is offered with palliative intent.

In 1994 a working group of the Standing Medical Advisory Committee (Standing Medical Advisory Committee, 1994) produced a report 'to provide, for all clinicians, guidance on current good practice in the clinical management of lung cancer'. The level of evidence for their recommendations was not stated. This has been followed by a number of different guidelines produced by various bodies involved with the management of lung cancer

patients (Table 1). Although all are based on the available clinical evidence, some cover only parts of the patient's care.

The government has stated that cancer is one of its top health targets. What are the important issues surrounding the organization of services at each stage of the cancer journey for lung cancer patients?

AT PRESENTATION

All published lung cancer guidelines assume that patients present to their general practitioner (GP) with a new symptom, the diagnosis is quickly made by chest radiography and a referral is made to secondary care for further management. There are difficulties at each stage:

- Perhaps only 50% of patients present in this way (Melling et al, 1998). The other half present either as medical emergencies or with unrelated symptoms and their tumour is picked up in the course of other investigations. There is evidence that patients presenting acutely have more advanced disease and do not fare as well (Scriven et al, 1998)
- The symptoms of lung cancer may be non-specific and GPs see them in large numbers

TABLE 1.
Published lung cancer guidelines

Issuing body	Year of publication	Whole cancer process?	Evidence based?	Core data set?
Standing Medical Advisory Committee	1994	yes	no	no
Lung Cancer Working Party of the British Thoracic Society (BTS)	1998	no	yes	no*
Scottish Intercollegiate Guideline Network (SIGN)	1998	yes	yes	yes
NHS Executive	1998	yes	yes	no
Royal College of Radiologists (COIN)	1999	no	yes	yes

*published without core data set, which was subsequently published in 1999

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of patients without an underlying malignancy. The 'average' GP will diagnose a new patient with lung cancer approximately once a year

- Since most patients with lung cancer have an abnormal chest radiograph, it is vital that GPs know which patients with new symptoms require a film and that an efficient open access radiography service exists. In some areas of the country an abnormal radiograph suggesting cancer automatically triggers a referral to the local chest clinic. This undoubtedly speeds up the diagnostic process, but many in primary care feel that this can confuse patients and take away their autonomy (Muers et al, 1999).

MAKING THE DIAGNOSIS

The diagnosis of lung cancer is usually made fairly rapidly once the patient reaches secondary care (Fergusson et al, 1996). This is usually done by a chest physician. Most respiratory units now have a designated lung cancer clinician and many have a dedicated lung cancer clinic. Patients not seeing a chest physician have more advanced disease and generally less chance of having a definitive diagnosis and active treatment (Fergusson et al, 1999).

It is important that the diagnosis and a management plan is communicated to the patients and their family in a caring manner and that good communication links exist between the chest physician, primary care, and tertiary services (Lung Cancer Working Party of the

Chest physician	Palliative care clinician
Radiation oncologist	Lung cancer nurse
Medical oncologist	Pathologist
Thoracic surgeon	Radiologist

Figure 1. The multidisciplinary lung cancer team.

British Thoracic Society Standards of Care Committee, 1998).

THE MULTIDISCIPLINARY TEAM

The care of lung cancer patients at the time of diagnosis and treatment often involves input from a large number of different health professionals. It is important that communication between these people is swift and effective and this has led most units to establish multidisciplinary lung cancer teams (Figure 1).

This practice is recommended by all the published lung cancer management guidelines. The precise membership and working arrangements of such teams may vary in different locations but should allow the discussion of management problems on a regular basis and should make the caring process as seamless as possible for the patient. The thoracic surgeon is a key member of the team but in many areas where they provide a regional service it is impossible for them to attend all the meetings of the teams they serve. This problem has been worsened by the national shortage of thoracic surgeons and perhaps developments such as telemedicine conferencing may help to resolve this issue.

THE LUNG CANCER NURSE

Many patients suffering from lung cancer have to cope with the problems arising from referral to many different clinicians in different specialities at the times of diagnosis, treatment, and follow-up. Continuity of care and the provision of informed support may be difficult for GPs during their patient's cancer 'journey' when communication between services may be slow.

To try and improve this situation hospital-based lung cancer clinical nurse specialists are appearing, with approximately 150 registered with a recently formed body: the National Lung Cancer Forum for Nurses. Some are funded from

TABLE 2. Possible roles for the lung cancer clinical nurse specialist	
To provide information and support for patients and their carers	
To aid communication between health-care professionals in primary, secondary, and palliative care during the cancer journey	
To help with symptom control (e.g. breathlessness and pain)	
To administer chemotherapy and monitor any toxicity of this treatment	
To facilitate audit	
To educate other nursing staff	
To encourage entry into clinical trials	
Health promotion (smoking avoidance and cessation)	

respiratory units or from charities such as Macmillan or the Roy Castle Lung Cancer Foundation.

The possible role of these nurses is outlined in *Table 2*. It is likely that these nurses will focus on one area of the cancer journey depending on their background. Often patients and their families can find the wait between investigations to establish a diagnosis and the onset of treatment a particularly difficult and worrying time. The lung cancer nurse can play a vital role in facilitating communication between services at this time, thus helping to ease the tension.

DATA COLLECTION AND AUDIT

The published lung cancer guidelines have laid down targets for clinicians regarding the process of care for various parts of the cancer journey. The government has recently committed doctors to some of these targets and patients are aware of this. A major problem for clinicians facing these hurdles is that data concerning the process of care are not routinely collected and most have no way of ensuring that their service is 'performing' within these targets. This may have special relevance as clinical governance standards are being set. Clinicians are now struggling to collect these data prospectively but this form of audit is expensive and time-consuming and the resources required to implement this exercise are not readily available to most. Minimum core data sets which relate to published guidelines are available (see *Table 1*) but many exist in paper rather than electronic form. Also most of these targets relate to the process of care, for example waiting times, rather than outcomes of treatment.

CONCLUSIONS

The care of patients with lung cancer is receiving higher priority from clinicians as published guidelines have appeared. Multidisciplinary

team working and specialized nurses should make the cancer journey smoother for the patient and their carers and hopefully improve their quality of life. However, more effective therapies are required to have an impact on the quantity of their survival. **HM**

Conflict of interest: none.

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KEY POINTS

- The process of care for lung cancer patients is changing.
- Guidelines concerning lung cancer management have been published.
- Multidisciplinary team working is starting.
- The lung cancer specialist nurse has an important role to play.
- Routine data collection is needed for clinicians to 'measure' their service.