**Imaging for urgent GP referrals in patients with suspected lung or pleural malignancy**

**Descriptor:**

Audit to assess compliance with NICE guidance [1].

**Background:**

**X-ray**

An urgent referral for a chest X-ray should be made by a primary health care professional (General Practitioner – GP) when a patient presents with unexplained symptoms and signs suggestive of lung cancer. The investigation should be performed (and presumably reported) within 2 weeks of request [1].

For patients over 40 years of age, unexpected symptoms and signs suggestive of lung cancer are:

• Cough

• Fatigue

• Shortness of breath

• Chest pain

• Weight loss

• Appetite loss

• Persistent or recurrent chest infection

• Finger clubbing

• Supraclavicular lymphadenopathy or persistent cervical lymphadenopathy

• Chest signs consistent with lung cancer

• Thrombocytosis

**X-ray report**

People with a chest X-ray result suggesting lung cancer have a copy of the radiologist's report sent to and followed up by the lung cancer multidisciplinary team [2,3]. Reports which require a fail-safe process for communication should be flagged appropriately [4,5].

**CT scan for diagnosis and staging**

Patients with known or suspected lung cancer on x-ray should be offered a contrast-enhanced chest CT scan to further the diagnosis and stage of the disease. The scan should also include the liver and adrenals. Not all patients will take up such offer.

## The Cycle

**The standard:**

• Chest x-ray should be performed and reported within 2 weeks of a received request

• Chest x-ray reports identifying suspected malignancy should be copied to the Lung Cancer Multi-Discipinary Team (MDT) Co-ordinator

• Chest CT should be offered to all patients with suspected lung cancer

**Target:**

100%

## Assess local practice

**Indicators:**

• Percentage of reports for patients with proven lung cancer received by the GP within 2 weeks of initial referral

• Percentage of initial chest x-ray reports for patients with proven lung cancer marked for and sent to the MDT Co-ordinator

• Percentage of patients with proven lung cancer offered chest CT

**Data items to be collected:**

• Consecutive new lung cancers from lung cancer data registry

• Time and date of GP request received for chest x-ray from hospital radiology information system (RIS)

• Time and date of relevant chest x-ray report on RIS.

• Review the radiology reports to assess whether the reports had been indicated as urgent with measures for urgent communication of the report to the MDT Co-ordinator and referrer according to local policy

• Communication data from RIS or departmental log

**Suggested number:**

At least 30 consecutive new lung cancers from GP referral. Six months data from hospital lung cancer registry would be optimal.

**Suggestions for change if target not met:**

• Encourage GPs to use electronic request for chest x-ray, all referrals; and mark appropriate cases as urgent

• Encourage radiographers to identify chest x-rays with significant pathology and place in priority reporting worklist

• Ideally all urgent referrals with symptoms suspicious of lung cancer should be placed in the priority reporting list to facilitate compliance with this guideline

• Encourage utilisation of digital dictation system

• Advocate one click electronic communication of report to GP and MDT Co-ordinator

• Clerical Team to facilitate fax log where relevant

• Repeat date for next audit (following change): six months

**Resources:**

• Local audit department for list of all new lung cancers in period of review

• Clerical time for performing the hospital information system check. This person needs appropriate clinical experience and skills to understand information presented in the Hospital Information system and to correlate with the images on PACS

• Clerical time to review fax/email log

• Audit lead to collate results and write report

• Allow eight hours for scrutinising records and preparing Formal Report

**References:**

1. NICE. Lung cancer: diagnosis and management. Clinical guideline NICE guideline [NG122] Published: March 2019 . [https://www.nice.org.uk/guidance/ng122](https://www.nice.org.uk/guidance/cg121/chapter/1-Guidance#access-to-services-and-referral)
2. NICE CKS. Lung and pleural cancers - recognition and referral (February 2021) [https://cks.nice.org.uk/topics/lung-pleural-cancers-recognition-referral/](https://cks.nice.org.uk/lung-and-pleural-cancers-recognition-and-referral#!scenario)
3. MacMillan Rapid Referral Guidelines (Cancer Support) 2015. <http://www.macmillan.org.uk/documents/aboutus/health_professionals/pccl/rapidreferralguidelines.pdf>
4. Royal College of Radiologists. Standards for the communication of radiological reports and fail-safe alert notification. May 2016. <https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr164_failsafe.pdf>
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**Editor's comments:**

This method of case identification will only assess the turnaround time for those patients with a subsequent diagnosis of lung cancer. The NICE guidance applies to all patients referred with features suspicious of lung cancer. Although more difficult to achieve identifying the cases to be assessed at the point of referral - at the time of vetting - would more accurately assess compliance with the NICE guidance.

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