Are We Achieving the Current Waiting Time Targets in Lung Cancer Treatment?

Sam Janes, PhD, MRCP,* and Stephen Spiro, MD, FRCP†

Most large hospitals in the United Kingdom will see 100 to 150 new cases of lung cancer a year, mostly as new outpatient referrals, but as much as 30% of patients are admitted through the emergency department to be cared for by a variety of disciplines. So, it is a significant load, and, for a disease for which the median survival is 8 to 9 months, it needs prompt and expert attention. Before the National Cancer Plan in 1997, there was no system of prioritization for suspected cancer referrals, and for those patients admitted, much depended on the specialty in charge as to what might happen and at what pace (let alone whether a respiratory referral was made!). The British government has made cancer care a priority, basically because British 5-year survival figures were considered inferior to those of other comparable European and western countries for several cancer types and because there was inadequate order in the organization of day-to-day cancer care. As discussed in the commentary by Devbhandari et al. in this issue of The Journal, the expectation is for patients suspected to have lung cancer to be seen within 14 days of a referral, diagnosed and staged with a decision for initial treatment within 31 days, and beginning treatment within 62 days of initial referral.1,2 In addition to forming regional cancer centers, each with several units (district general hospitals), the development of weekly multidisciplinary team (MDT) meetings and provision of clinical coordinators to run these meetings, follow patients and speed up tests, the setting has been laid for improvement.

Whether lung cancer outcomes have improved is hard to say and depends on how one defines improvement. Clearly, for the patient there has been a remarkable speeding up of initial consult, having tests and biopsies, and being brought to a MDT for a treatment discussion. Most agree that there is little delay in the initial clinic visit, although many urgent referrals are clearly not, and there is considerable abuse of the system. This may not be the fault of the referring community physician, as lung cancer has few specific symptoms, and the average general practitioner may see only one or two new cases a year, among hundreds with cough, chest infection, wheeze, etc.

Incumbent on rapid assessment has been the reorganization of imaging and endoscopy departments. Some centers have instituted a one-stop approach with same-day computed tomography (CT), discussion, and transthoracic or bronchoscopic biopsy. Others have reserved CT slots and hold weekly meetings to arrange the most appropriate route for diagnosis and staging, again with reserved places. For the great majority of cases, a CT and single biopsy procedure yields the diagnosis, and well within 31 days. Difficulties arise if initial biopsy approaches are inconclusive and/or sophisticated staging is needed with positron emission tomography, with which there can be significant delays because of the national shortage of these scanners.3

Once the decision to treat is made, there is a month to do so. This is not challenging for thoracic surgery or for chemotherapy, as the guidelines state that patients with small cell lung cancer should begin chemotherapy within 1 week, and patients with non-small cell lung cancer should begin chemotherapy within 1 week.
cell lung cancer should begin chemotherapy within 4 weeks. Radiotherapy departments may cause delays in radical field planning because often there is a failure to prioritize lung cancer. However, all this is achievable.

Will the changes make any difference? Yes, it will make the patient journey faster and more efficient, although patients may not want to proceed at this speed and may lose contact with their initial physician, risking communication problems, at a time in their lives when huge decisions need to be made. The MDT and the organization around it make it difficult for a patient to drop out or be forgotten. It also provides a conduit for all patients with lung cancer to be presented, preventing other medical groups from hanging onto these cases.

The funding of a national data set for lung cancer (LUCADA) will provide a unique opportunity to follow the standards of lung cancer care in the United Kingdom. More than 800 patients a month are being entered from all over the country and this should now increase as data entry becomes mandatory. However, the most important question is whether this political innovation to improve the patient journey will improve survival for the disease, which is the main objective. Improving the patient journey alone may improve survival for a few patients previously not offered prompt expert exposure who may now undergo an operation, radical radiotherapy, etc. However, the most important determinant of survival is the innate biology of the tumor. Rapidly growing disease is unlikely to be converted from incurable to curable by a few weeks’ faster detection, and slowly growing cancers may still be curable if missed for 6 months. With doubling rates of 30 to 120 days, and the average lung cancer presenting at 3 to 4 cm in diameter on a chest radiograph, 35 volume doubling times (3 to 12 years) will have passed before diagnosis, making the weeks saved by the National Cancer Plan irrelevant. Nevertheless, it has introduced an improving system of care, a welcome reorganization of MDT working, an opportunity to improve entry of patients into clinical trials, and a national data set that will become the benchmark for future improvements in care but probably not have much effect on overall cure rates.

REFERENCES