key points

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Although the five-year survival in the UK has improved from 10% to 14.5%, the UK still lags behind other comparable countries, where five-year survival figures are around 20% or more. Presentation via an emergency route remains a problem: 33% of patients were diagnosed following an emergency presentation in 2016. These patients have much poorer outcomes than those who are diagnosed by other routes with only 16% surviving a year and more than a third dying within a month.

NICE recommends urgent referral via a suspected cancer referral pathway to the two week wait service if: chest X-ray findings suggest lung cancer or if patients aged 40 and over have unexplained haemoptysis. However, studies have indicated that around 20-25% of patients with confirmed lung cancer may have a chest X-ray reported as normal and this figure may be higher for early stage lung cancers. Therefore, the National Optimal Lung Cancer Pathway (NOLCP) recommends that where there is a high suspicion of underlying malignancy (but the chest X-ray is normal), GPs should refer patients directly for a CT scan.

There is mounting evidence that time to diagnosis is important in lung cancer. This may be because performance status (a measure of fitness) deteriorates rapidly in some patients and this is one of the strongest predictors of survival. The NOLCP recommends urgent reporting of chest X-rays suspicious for lung cancer, with CT scanning completed the same day or within 72 hours, followed by review in the fast track lung cancer clinic. CT should be carried out with administration of contrast and include the lower neck, chest, liver and adrenals.

Positron emission tomography-computed tomography is an important staging investigation and is recommended in those patients who are deemed suitable for treatment with curative intent. It is useful in assessing mediastinal nodal involvement and has a key role in detecting metastatic disease. NICE recommends brain imaging in all patients with stage II or IIIA non-small-cell lung cancer (NSCLC) who are suitable for treatment with curative intent and in all those who present with clinical features suggestive of intracranial pathology. In most patients who are potentially suitable for treatment, a tissue diagnosis is required to guide further management.

Surgery remains the preferred treatment in early stage NSCLC and gives the greatest chance of cure. Patients with early stage NSCLC who choose not to have surgery, or are not good surgical candidates, should be offered radical radiotherapy in the form of stereotactic ablative radiotherapy. Small cell lung cancer SCLC is usually incurable at presentation although patients with very early disease may be considered for surgery with adjuvant chemotherapy. For the majority of patients with extensive disease the priority is to commence chemotherapy as soon as possible.