Meeting of the SWAG Network Lung Cancer Clinical Advisory Group (CAG)

Tuesday 3rd December 2024, 10:00-15:30

Aztec Hotel, Almondsbury, Bristol, BS32 4TS/ MS Teams

This meeting was sponsored by Amgen, AstraZeneca and MSD

Chair: Dr Ashley Cox

REPORT (To be agreed at the next CAG Meeting)	**ACTIONS**

1. Welcome and apologies

Please see the separate list of attendees and apologies uploaded on to the SWAG website here.

There was good multi-disciplinary representation from across the region.

2. Review of last meeting's report and actions

As there were no amendments to the report from the previous Lung CAG, held on Tuesday 14th May 2024 the report was agreed as finalised.

The majority of action points on the Work Programme are on the agenda today.

Research

3. South West Central Research Delivery Network (RDN)

Please see the presentation uploaded on to the SWAG website

Presented by Research Delivery Manager Claire Matthews and CAG Research Lead Gareth Ayre

The Research Delivery Network for South West Central is a new organisation, established in October 2024, which has been adapted from the previous Clinical Research Network.

The vision is to make the UK a global leader in the delivery of high quality commercial and non-commercial research that is inclusive, accessible and improves health and care.

The purpose is to support research delivery as an active partner, and to increase capacity and capability of the research delivery infrastructure.

The support provided will be strategic in nature rather than focused on monitoring individual trial performance.

Chief Investigators are able to contact the RDN to request support if a trial requires additional resources.

Extra funding is going to be provided to recruit additional research nurses, and project funding will be available for teams via an application process.

There is also an Agile Delivery Team of research nurses and clinical practitioners that mainly work in out of hospital settings but could be deployed to help teams in hospitals as well.

Changes had been made to standardise the research networks into a single, customer focused, value for money organisation.

The number of networks has been reduced and the West of England CRN renamed 'South West Central'. Dorset and Salisbury have been added to the RDN region, which still doesn't map to SWAG, as Taunton and Yeovil are still included in the Peninsula RDN. However, the RDNs will continue to work closely together to ensure data is shared with the SWAG Cancer Clinical Advisory Groups.

RDN services are currently being developed.

National recruitment to Lung Cancer Trials was 14,447 across 165 trials between April 2023 to March 2024 and 9,582 recruited to date since April 2024 across 134 trials. There is a fairly even split between commercial and non-commercial, with 64.2% being interventional.

The list of trials open across the region are documented in the presentation.

Mesothelioma:
Recruitment to MITOPE has had to stop in NBT due to capacity issues. Meso-ORIGINS is still open, which is a CRUK observational study run by the Glasgow team to look at pre-cursers to mesothelioma.

HIT-Meso is a randomised controlled trial (RCT) which will compare standard treatment versus proton hemithorax irradiation for mesothelioma. The proton treatment needs to be given in UCL or Manchester, although recruitment can be arranged elsewhere.

NBT are hoping to open as a Patient Identifying Centre (PIC).

It would be helpful to also open a PIC in Exeter.

eVOLVE-Meson is open in Musgrove and will compare Volrustomig versus standard care.

Peri-operative:
Yeovil have a randomised trial open that provides a home-based exercise programme in early-stage disease; this is not just for lung cancer.

BHOC are due to open a personalised cancer vaccine study this month for patients with resectable non-small cell lung cancer who would normally have pre-operative Nivolumab and perioperative Pembrolizumab as standard care, and who have not had a complete pathological response (CPR). Patients can be randomised to receive the vaccine in the adjuvant setting, with the resected tumour being sent off for genomic analysis.

Patients can have their neoadjuvant SACT in their local centre but would need to come to BHOC for 4 cycles of perioperative treatment.

Regional colleagues are encouraged to refer any relevant patients.

It has been estimated that 60% of patients will be eligible. BHOC plan to register all relevant patients and hope to arrange consent once CPR status has been confirmed.

Those who are not randomised to receive the vaccine can be referred for adjuvant treatment at their local centre.

Action: To provide a summary of the vaccine trial to facilitate initial conversations/manage patients' expectations. Gareth Ayre

Eligibility criteria includes having a PET-CT within 6 weeks prior to entering the trial; further information will be gathered to see if this applies to patients who enter the trial after having surgery.

Stage 3 NSCLC:
Cheltenham have opened PACIFIC-8, which is an RCT that will compare Durvalumab +/- Domvanalimab following chemo-radiotherapy (CRT) for inoperable Stage 3 NSCLC. BHOC currently have PACIFIC-9 open, which is expected to close to recruitment in the next few months. It is a 3 arm study that will compare Durvalumab +/- Placebo, Oleclumab or Monalizumab following CRT for inoperable Stage 3 NSCLC.

Metastatic NSCLC:
Several centres have opened REFINE, which is looking at the optimal maintenance Pembrolizumab dosing interval after 6 months. Patients will be randomised to 5 different arms. If progression occurs on the longer interval arms, there is the option to move patients back on to the 6 week interval.

Cheltenham have opened TROPION 10 for patients who are treatment naïve and have locally advanced or metastatic NSCLC with a high PD-L1 expression, to evaluate the efficacy and safety of Dato-DXd in combination with Rilvegostomig or Rilvegostomig monotherapy compared with Pembrolizumab monotherapy.

SCLC:
PRIMALung is open in BHOC and Cheltenham and is looking at MRI surveillance and treatment at relapse +/- prophylactic cranial irradiation.
It will assess the neurocognitive toxicity of treatment and impact on quality of life.

Radiotherapy:
TOURIST is due to open soon in BHOC, Cheltenham and Musgrove, which is a Phase 3 trial evaluating the efficacy of radiotherapy in treating Stage 4 NSCLC using advanced radiotherapy techniques. It has two parts; the PRINCE part involves patients randomised to receive SACT alone or SACT with moderate dose RT. The QUARTZ part is for patients who are unsuitable for SACT who would be randomised to Best Supportive Care (BSC) versus upfront RT.

QUARTZ will generated additional oncology appointments as this patient cohort would previously have been discharged straight to palliative care.

Non-tumour specific:
MITRE is an observational study looking at the impact of the microbiome on immunotherapy toxicity and efficacy and involves faecal swabs. There is some evidence on this already, but MITRE is examining this in more detail.

WAYFIND-R is a register study evaluating the impact of Next Generation Sequencing (NGS) on treatment selection and outcomes.

Trials in set-up:
BHOC have been selected to open the following 2 studies in the next few months:

BRAF V600E is a Phase 2 trial for NSCLC and other cancer patients that

have been pre-treated with BRAFi and PDL1i and provides the opportunity to access an oral BIDAC degrader +/- trametinib; Phase 1 results have shown good responses.

KRASCENDO-2 is a first line trial for NSCLC with KRAS G12C to compare Divarasib plus pembro versus chemo + pembro.

CAG members are invited to share information on any trials not listed today.

REFINE-Lung trial team are also seeking new sites. Contact details and further information is documented in the presentation.

LungFit, introduced by Research Nurse Suriya Kirkpatrick in the previous meeting, is now open to recruitment for patients with lung cancer who have a Performance Status (PS) of 1 or below. The trial involves accessing a digital self-management app that provides a bespoke exercise programme. Exclusion criteria includes patients with bone or brain metastases or patients already on an interventional prehab study. Enrolment involves a visit to Southmead Hospital.

Action: To contact individual Trusts prehab teams for assistance with recruitment. Suriya Kirkpatrick

The surgical team also have a study with an app which tracks steps versus normal care which closes in April 2025.

Action: To send a link to the QR code for the national BAP1/MTAP survey for Lung CAG to complete. Anna Bibby

4. Clinical Nurse Specialist Update

Presented by the CNS Teams

The Surgical Clinical Nurse Specialist in UHBW is going to expand the nurse-led surgical follow up clinics, which have been running in the BRI for some time, to the Weston site.

A CNS-led surgical follow up clinic in RUH is in the negotiation stage at present, with protocols being agreed, and support from Thoracic Surgeons being arranged.

RUH CNS team remain very busy at present. The Lead Cancer Nurse for the Trust is looking at CNS activity and the time spent on administrative tasks to see how this might be managed differently. It is hoped that this may free time to take more of an active role in facilitating recruitment to research.

A Patient Experience Audit is underway to assess a relatively new CNS service that has been up and running for 2 months.

Potential future agenda item

UHBW CNS Team have seen a significant increase in referrals over the past few months. The team is expanding with an additional CNS starting in post in the near future.

GRH have established CNS-led surgical follow-up clinics and are in the process of reviewing the CNS Banding before expanding roles and responsibilities further to support oncology clinics, in light of the increasing number of patients identified via the Lung Cancer Screening Project. This is leading to an increase in patients having SABR; it would be a more formal way to manage those relatively stable patients with Stage 3 disease as they become more symptomatic.

An assessment of the workload activity is underway to plan the future workforce, and a business case will be presented to Gloucestershire ICB to try and secure additional funding.

Salisbury FT have just secured additional funding for one 0.6 Whole Time Equivalent (WTE) Band 6 CNS. The whole team is now 2.6 WTE including a Band 7. CNS-led clinics have been established, alternating with Consultant Respiratory Clinics for follow up. The surgical model is different, as the surgical pathway goes to Southampton. It involves a Thoracic Nurse Telephone Consultation from the CNS in Southampton prior to referral back to the Consultant Respiratory Physicians for ongoing follow up, which works well.

A Cancer Support Worker has been appointed to help manage the CNS administrative workload, including completion of Holistic Needs Assessments.

CNS Banding needs to reflect the CNS workload and be consistent across the region.

Clear guidance is required on the range of tasks allocated to the CNS role as the remit is continually being expanded, plus embedding the correct amount of administrative support.

Action: Lead Cancer Nurse Chris Levett will provide support from a Cancer Alliance perspective. **Chris Levett**

5. Targeted Lung Health Check Programme: (TLHC) Updates since May 2024

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician Anna Bibby

National data from the TLHC programme hit >5,000 cancers diagnosed in recent weeks, 75% of which identified at Stage 1 or 2, meeting the national target and completely reversing the trend of cancers identified at a late stage.

Locally, the team have diagnosed 131 cancers, 81% of which were diagnosed at Stage 1 or 2. It was acknowledged that the BRI team have had a particularly high influx of referrals over the past 9 months.

Approximately 300 people have stopped smoking following advice from the service.

Specific outreach work is underway to target underserved members of the population, with the TLHC service travelling to Leyhill Prison; 70 assessments were completed, half of which met the criteria for requiring a scan. This is a higher percentage / higher risk population than average.

The plan for further roll out has been running ahead in BNSSG as the rotation to BSW has been delayed awaiting set-up in Salisbury.

The order of roll out is organised by identifying the Primary Care Networks (PCNs) that have the highest need.

The Screening Review Meeting (SRM) is where all positive CT findings, (including incidental findings and nodules) are discussed. Approximately 16% of positive findings can be downgraded to non-urgent management.

The plan is to devolve the SRM to the individual Integrated Care Boards (ICBs), starting with Somerset, aiming to split into 3-4 independent hubs by April 2026. Appropriate clinicians to manage Somerset SRM have already been identified.

The ICBs will manage governance of the SRMs as it has not been possible to find a single central solution for managing local referral pathways.

Radiology cover is challenged in some areas and it is recognised that additional cross-cover needs to be provided.

It is planned to start scanning patients in Gloucestershire in January 2025. This was delayed by a year due to the implementation of a new PACS system and sign up from Primary Care due to the number of incidental findings that are referred back with advice and guidance. GPs are recompensed for registering and monitoring these conditions, but it is recognised that the TLHC programme initially results in a wave of extra referrals.

Two practices have declined to sign the Data Sharing Agreements (DSA) required for the TLHC programme as the activity was not considered to be included in GP contracts. It was felt that this was a national problem that needed to be resolved and, in the interim, the SWAG TLHC multi-regional model allows TLHC activity to rapidly move to alternative areas when blocked from screening elsewhere.

National solutions have been proposed to not report on some of the milder findings and to draw on other resources such as the over 40's health check.

Research has been embedded in the service from the beginning. All of the social commentary around the project is going to be extracted and presented. The other studies underway are listed in the presentation.

Thanks were given to the clinical team members who have helped facilitate the programme.

Discussion:

The national target for 100% roll-out is 2029/30, which would generate an additional 17% screening per year for the SWAG population.

25,000 (7%) of the population have been screened to date plus another 350,000 left to screen. Central funding is available for the screening activity but not for the downstream work, which will need to be managed locally.

Another reason for devolving the SRMs is to ensure local teams are aware of the impact on services when screening is active in the area, and of the additional resources required for this to be managed.

For the incidental finding of moderate coronary calcification, early detection can improve outcomes by provision of Statins, there is no evidence for mild calcification, which has been removed from the

reporting guidance. Reporting of emphysema is not a screening related disease as early detection does not improve outcomes, although smoking cessation and pulmonary rehabilitation would reduce hospital admissions and improve quality of life, therefore it is not feasible to offer spirometry as part of the health check.

Referrals to specialties other than cardiology have also increased, in particular to urology, radiology and breast cancer services.

The impact may be felt across all Secondary Care services as it is not a screening tool specific to ruling out one disease.

Sharing the programme information with as many specialties as possible, as has been attempted in RUH and other centres, and conveying the message that it is identifying their future patients at an earlier stage, will help with managing expectations of the increase in referrals, with recognition that it will take time to raise awareness across the board. However, it is recognised that NHS services from Primary Care and in all specialist areas were beyond available capacity prior to commencement of the programme.

GP Representative Glenda Beard has been speaking to colleagues across the region who are keen for the incidental findings to be reported as this supports the prevention and early diagnosis health checks. Managing the workload is a challenge as it occurs in a wave; it is also not directly funded as the activity to reach a diagnosis has not occurred in the Primary Care setting - further funding needs to be allocated.

Research is also underway to try and improve uptake to the screening programme.

6. Cancer Alliance update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Respiratory Physician Henry Steer and Cancer Alliance Programme Manager Nicola Gowen

The National Cancer Treatment Variation Work Programme commenced following the Getting it Right First Time (GIRFT) peer review of Lung Cancer Services, resulting in the CAG choosing 3 metrics in 2022 to measure improvements to the service. Data has since been regularly submitted to the National team based on those metrics but the quality of that data has always been a problem; the aims of the programme have since been modified and the metrics no longer need to be reported.

All Trusts, aside from RUH, had installed a data collection tool created by ROCHE to assist the reporting process but the data definitions within it have proved difficult to marry up with Trust systems.

For 2025/26, the treatment variation work, which comes with funding, will now focus on one metric: 'To ensure at least 70% of patients with NSCLC stage IIIB-IVB and PS 0-1 receive systemic anti-cancer therapy (SACT) in line with NICE guidance.'

Data from the National Lung Cancer Audit (2023) shows three Trusts within SWAG falling below this target. This was felt to be a data collection issue as the majority of these patients are known to be treated with SACT.

The national team plan to continue to scrutinise the cancer waiting time targets, in particular, the days between diagnosis and the decision to treat.

Lung CAG agreed to stop collecting the original metrics, which were not adding value due to data inaccuracies. **AGREED**

Ideally, MDT Leads need to take ownership of their data quality by checking the information recorded on a monthly basis.

It is possible to download a spreadsheet of information on each patient from the GRH Infoflex system, which Consultant Respiratory Physician Henry Steer can check and correct.

It is not possible to download a spreadsheet of information from the Somerset Cancer Register (SCR) as the majority is not within searchable fields.

Agreement of a network audit may be the most valuable data collection exercise.

7. CNS Surgical Follow Up Guidelines: ratification of Standard Operating Procedure (SOP)

The existing UHBW protocol created by the surgical team has been adopted as the SWAG wide Surgical Follow Up Guidance. It has been slightly simplified following discussion with a working group, as there were some inconsistencies arising from international guidance and has been sent for ratification. No comments have been received to date.

It was agreed that a letter to report a clear CT scan was sufficient after

three years of follow up.

CNS teams track follow up requirements on local systems. It would be ideal to have a tracking system that would flag when surveillance scans are due. This has been piloted on the My Medical Record (MMR) system for patients with colorectal cancer and is due to roll out to Gynae patients next. If successful, it could be used for lung cancer in the future.

Action: To arrange for patient and radiology input into the content of the SOP.	**Sara Gomez**
Action: To collect data on follow up outcomes.	**CNS team**
Action: to resend the SOP for ratification to the group by 6th January 2025	**Helen Dunderdale**

8. Thermal Ablation (TA) Services

Presented by Consultant Radiologist Emily Bartlett on behalf of TA Lead Carole Ridge

Following review of the GIRFT report in the previous meeting, it was recognised that SWAG currently do not have access to Thermal Ablation as a treatment option, prompting the team to invite a member of the Royal Brompton team to explain the service so that they can learn about the patients that are eligible for the treatment.

The TA service at the Royal Brompton has 1 General Anaesthetic (GA) List per month for 2-3 patients. Ad hoc cases can be arranged in the interim. Approximately 50% of the nodules ablated are primary lung cancer and the other 50% are metastatic disease, most of which are of colorectal and sarcoma origin.

Treatments for lung cancer include both microwave and cryo-ablation. Microwave ablation is a heating treatment that is quicker than cryo-ablation, taking about 2-10 minutes. Two different microwave systems are used - 'New Wave' and 'Angio-Dynamics'. Patient are selected for the most appropriate treatment depending on the particular configuration of these systems.

Cryoablation involved a cooling therapy using Argon to induce cell death by repeatedly freezing and thawing the lesion. The disadvantage is the increased length of time for the process, but it is useful for sub-pleural lesions, where burning of the pleura would cause considerable pain, and in people with fibrosis or a lesion near to high risk structures.

Some literature suggests that patients receiving cryo-ablation may be slightly more likely to bleed than those receiving microwave ablation.

Several probes are required for cryoablation, whereas microwave ablation requires one.

Examples of patient selection:

- Stage 4 lung cancer treated with Chemo-Radiotherapy no longer suitable for further radiotherapy with a single pleural metastasis invading the second rib
- Decision: Suitable for cryoablation.

Patients must have a good performance status, life expectancy of >1 year, lesions under 3cm, and no more than 5 lesions.

If a patient has multiple stable metastases and one starts to grow, it may be decided to ablate that particular lesion.

Ablation is selected for patients where it is not possible for any more lung to be surgically removed, or lesions that are too deep to palpate, or when the patient has not been able to tolerate SACT or has a recurrence in an area previously treated with RT. Markers are implanted to guide treatments.

Cardiothoracic Anaesthetists are on site who can intubate the patients with a double lumen airway, so it is possible to ventilate the contralateral lung and keep the other still during the procedure. This is also useful in the rare event that bleeding occurs.

95% of procedures are undertaken using GA. Occasionally patients are ablated under local anaesthesia who are not able to tolerate a GA.

The ablation needle is inserted prior to inserting a biopsy needle as it is possible to lose sight of the lesion if the biopsy causes a bleed or pneumothorax. A biopsy is required both to confirm the diagnosis and to send for molecular analysis to guide oncological treatment options in the event of another recurrence.

Evidence of the benefit of TA is very heterogeneous with varied ablation methods being published, and the duration of follow up also being varied.

There is currently insufficient evidence of benefit to ablate SCLC.

Literature shows recurrence rates of NSCLC of approximately 20-30%; this is however dependent on tumour size, with another publication

showing recurrence rates at 1 year of 6% for lesions with a median size of 11mm.

Lesions above 3cm are not ablated due to poor outcomes.

Further evidence is required, but local evidence shows positive outcomes.

5 year survival is low, which is to be expected due to the patient cohort selected for ablation.

ESMO and ACCP guidelines recommend ablation for Stage 1 inoperable lung cancer (<3cm lesions). Interventional Radiologist Guidelines recommend ablation for lesions <2cm. NICE guidance requires updating with more recent evidence.

A complicated case study was presented where an awake ablation was undertaken on a patient with Interstitial Lung Disease using breath holds, with the less aggressive Angio-Dynamic probe, for a deep small single metastasis. A generous dose of local anaesthetic was provided plus diclofenac. Some chest pain was experienced afterwards. Outcomes are good at 6 months.

Discussion:

Lung CAG are invited to refer patients with >5 lesions of stable metastases >3cm who are not suitable for other treatment options:

Emily.Bartlett@nhs.net
C.Ridge@rbht.nhs.uk

SWAG Consultant Radiologists are invited to visit the Royal Brompton Team should they wish to observe the procedure.

9. Surgical Service update

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Thoracic Surgeon Stelios Gaitanakis

The thoracic surgical 62 day backlog recovered in May 2024 following a very difficult period of time for the service at the beginning of the year. Since the recovery, management reduced the number of lists and waiting times started to increase again. It has now been possible to renegotiate the number of lists required. This will again involve undertaking weekend lists and operating until 7-8 PM in the weekdays.

It is hoped to rearrange job plans for the Consultants to optimise the balance of the workload.

The theatre now has some new Video Assisted Thoracic Surgery (VATS) sets to help manage the increasing number of segmentectomies. 3D planning has been incorporated, and over 100 cases have now been performed using the robot, which has been shown to decrease patients Length of Stay (LoS).

From April, an additional 2 surgeons (4 out of 6) will have been trained to use the robot.

The team have taken part in a powered staple trial which reduces complication rates.

The team are trying to acquire a C Arm to help with Navigational Biopsy and talks are underway with respiratory physicians about providing cryo-biopsy.

A theatre refurbishment is pending, but negotiations have been made to ensure that thoracic surgery will not be disrupted.

It is hoped that the benign surgery service can recommence in the near future, as was provided pre-COVID. This has the full support of the Division.

Details of the current team are documented in the presentation.
It is hoped to secure funding to appoint an Advance Nurse Practitioner.
The recent recruitment of a Navigator has helped to improve the pathway.

Nurse-led surgical follow up clinics are being introduced in other centres.

In the future, it is hoped to reinstate virtual pre-operative assessments.

TLHC referrals tend to come in waves, which has caused some confusion with the original workload projections.

A second robot is due to arrive in 2025 and it is hoped to secure additional theatre lists.

BRI rapid clinics have been established to follow the MDT, which means that patients don't have to wait to receive their MDT decision. This has improved cancer waiting time breaches for patients aside from those who need multiple complex investigations.

It is hoped to see more patients in local hospitals in the future.

Parallel surgical and oncology clinics have been arranged in Manchester for complex Stage 3 patients. This may be challenging to arrange with equity across the SWAG geography.

Action: To add review of clinic configuration to a future agenda item

10. Genomic Medicine Service Alliance (GMSA) update — **Helen Dunderdale**

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Medical Oncologist Louise Medley

The GMSA is in Phase 3 of the roll out of ctDNA tests for NSCLC with the aim to move towards providing the tests for all patients with Stage 3B/4 disease.

All 9 Trusts in the South West GMSA are submitting tests with 359 sent to date, which is an average of 51 tests per month. A weekly Genomics Expert Advisory Board (GEAB) has been set up which has been running for approximately 3 months, attended by approximately 50% of the Trusts.

Turnaround times for test results from the time that the Royal Marsden receive the test kit is 14 days. This has been hampered recently by technological problems. These have caused more failed samples which they have since had to re-run. In the interim, some samples have had to be sent to an alternative laboratory and so a mixture of reports may be received.

In-patients can be captured by adding ctDNA to the Acute Oncology request bundle.

Eligibility criteria included PS 0-2.

The Salisbury team are welcome to join the South West GEAB.

Lung CAG are asked to consider how the GMSA can help improve uptake, whether this is by provision of phlebotomy training or any other aspect of the logistics required.

It is hoped to improve attendance at the GEAG.

The GEAG clashes with the screening SRM which needs to be prioritised.

An additional date has been arranged so the meeting is now also every other Tuesday afternoon at 15:30 as well as every other Friday.

Diagnosis via ctDNA results should ideally be integrated in the MDT outcomes and National Datasets. However, ctDNA results are not usually available at the point that it is decided to refer to oncology.

Should a ctDNA test result return a positive result for NSCLC prior to the return of histology, it is hoped that there will be growing confidence to act on the result and aim to get patients rapidly started on treatment.

When an EGFR mutation is reported this is straight forward, and the reports are clearly interpreted and can be acted upon.

Efficiencies could be made if it was possible for the results to be imported on to the pathology reports, or on a searchable portal, rather than emailed as a PDF.

CAG Recommendation

Molecular Testing turnaround times for DNA and RNA are now between 10-14 days. Failure rates have dropped since the team started dual extraction to 12%, which is the lowest rate in the country.

The report will be modified over the coming year, with additional gene targets being added at pace.

Oncologists will record if a gene target has been identified in the patient records, however further governance on the availability of the results is required. For example, should a patient pass away elsewhere and have a germline mutation that requires family members to be referred to clinical genetics.

In Torbay, it is planned to hold a separate molecular MDT to report results back to the main MDT and ensure that these are actioned, rather than having repeat patient discussions in the main MDT.

11. The evolving world of peri-operative treatments and NICE approvals

Please see the presentation uploaded on to the SWAG website

Presented by Consultant Clinical Oncologist Ashley Cox

Two new NICE TA's have been approved since the previous meeting.

Previously, the treatment pathway was simple, with provision of surgery followed by adjuvant chemotherapy, resulting in a 5% increase in survival outcomes, plus radiotherapy for R1 disease.

It is vital to confirm EGFR and ALK status as the presence of these gene mutations make PDL1/P1 immunotherapy ineffective.

Although surgery is still the main treatment option, 5 year survival outcomes remain poor. However, advances are being made. The introduction of adjuvant Osimertinib has increased overall survival for patients with an EGFR mutation.

A crib sheet is now available in the MDT that lists the indications for different gene mutations.

Osimertinib can also be given in a palliative setting, for which the median survival is 3 years.

Median disease-free survival has recently been improved for metastatic patients with an ALK mutation with the introduction of adjuvant Alectinib.

Checkmate-816 has been available over the last year for patients with operable EGFR/ALK negative NSCLC <4cm. Patients were randomised to standard chemotherapy versus 3 cycles of chemotherapy plus nivolumab followed by surgery and optional adjuvant chemotherapy +/- radiotherapy. Twenty four percent had a complete pathological response, 99% of which are still alive after 3 years, 90% of which remain relapse free.

The attrition rate of those patients proceeding to surgery following neoadjuvant treatment is approximately 15-20%, 6-7% of which are due to disease progression. Both surgical and oncology colleagues need to emphasise to patients that they may not proceed to surgery should they opt for this treatment option.

Some patients choose not to progress to surgery following treatment.

Five additional trials are now available that offer peri-operative chemo-immunotherapy, followed by adjuvant immunotherapy.

KEYNOTE-671 has been approved and is available in local centres.

AEGEAN will also be coming in the next few months.

The current options for resectable NSCLC are summarised in the last slide of the presentation.

Discussion:

Treatment with adjuvant immunotherapy should commence as soon as possible following surgery.

Although some driver mutations do respond to chemotherapy, such as KRAS, there may be others, in addition to EGFR and ALK, that don't. These are rare and not often reported in trial data to date.

Neoadjuvant treatment should not be the blanket option for all patients if oncologist opinion is unclear on the benefit of immunotherapy and where there is a risk that delaying surgery will cause the disease to be inoperable.

Action: To look at local data on rates of referrals to neoadjuvant treatment, treatment intent, and outcomes. **To be allocated**

12. Bristol neo-adjuvant chemo-immunotherapy audit plus ratification of Standard Operating Procedure

Please see the presentations uploaded on to the SWAG website

Presented by Thoracic CNS Sara Gomez

The audit was undertaken by Consultant Thoracic Surgeon Stelios Gaitanakis and CNS Rachel Houston. It is planned to present additional data at the next meeting. **Future agenda item**

From August 2023-2024, 48 patients were referred from regional MDTs as potential candidates for neo-adjuvant treatment; 27 completed the treatment pathway and 21 did not.

For those who did not complete the treatment pathway, 8 were referred for upfront surgery. Further details are documented within the presentation.

Perioperative data showed that 60% of patients surgical procedure was completed via VATs, and 25% converted to open. 25% were admitted to ITU. Mean Length of Stay (LOS) was 5 days. Local data on surgical approaches was found to be comparable with national data.

Operation notes indicate that the dissections were lengthy and more complicated due to the presence of adhesions. Many of the conversions to open have been planned in recognition of this, with the initial VATS approach being an assessment of whether to proceed to open, which is again reflected in the number of expected ITU admissions.

No patients had to return to theatre and there was no surgical related mortality.

Post operative histopathological analysis downstaged 70% of patients, 30% of which had a complete pathological response.

Although neoadjuvant treatment has its challenges, with some patients' surgery delayed due to toxicities, the outcomes in downstaging the disease have been successful for the majority.

Opinions were sought on the provision of PET post treatment with SACT/IO.

Discussion:

Although PET had been used in the original trial, it had been agreed in the last meeting that CT was sufficient; immunotherapy can cause nodules to become enhanced on PET.

Action: The neoadjuvant SOP will be recirculated again for final ratification. — **Helen Dunderdale/Lung CAG**

13. National Lung Cancer Audit (NLCA) Update

Please see the presentation uploaded on to the SWAG website

Presented by NLCA Clinical Fellow / Cardio-thoracic Trainee Lauren Dixon

NLCA are trying to use the most recent data available from the rapid cancer registration dataset used since the COVID-19 pandemic to inform service improvements, although it is recognised that this will contain flaws, such as missing data in the patients' treatment pathways.

The dataset for Wales is currently provided within a different time

frame and work is underway for this to align with England.

A new online interactive dashboard is now available which provides Trust level data.

The most recent State of the Nation Report, published in April 2024, showed an increasing number of lung cancers being diagnosed, with 36,886 patients identified in England during 2022, 1087 of which were diagnosed via the TLHC programme, and fewer patients diagnosed at a late stage.

Highlights from the 2022 report are documented in the presentation.

In the event that Quality Indicators from the NCLA are found to be consistently above or below the National average, individual Trusts will be contacted by letter to raise awareness should improvements be required and to share practice, where results have been positive.

Treatment variation had been identified relating to provision of SACT. A paper is due to be published on the subject and will be presented at the next British Thoracic Oncology Group (BTOG) meeting.

Data from molecular tests is starting to be collected in the hope of linking this with the SACT dataset and reporting on additional Quality Indicators in the future.

In future, it is hoped that the COSD data field CR1600 – '17. Screening' will be entered for those patients identified via the TLHC programme.

The audit will return to collect the data field 'Trust first seen', rather than 'Trust first Diagnosed' to reflect that this is sometimes not the same organisation.

Feedback on the quality of data collection would be welcomed from Lung CAG.

Contact details:

- ldixon@rcseng.ac.uk
- nlca@rcseng.ac.uk
- lungcanceraudit.org.uk.

14. One stop diagnostic clinics

GRH have moved Lung Cancer diagnostics to the Community Diagnostic Centre (CDC). Patients attend for a CT scan and lung function tests. Further details will be provided at the next meeting due to time

constraints.

15. Any Other Business

Self-referral for chest x-ray was proposed by Cancer Alliance Clinical Director Helen Winter as a potential service development; this will be discussed at a future meeting when outcomes from a pilot centre can be made available.

Virtual POAC will also be discussed.

Date of next meeting: Tuesday 20th May 2025, 10:30-16:00

-END-