Lung Mass and Nodule Clinic at Western Health:

Western Health offers a multidisciplinary approach to the diagnosis and management of lung nodules and lung cancer.

The Lung mass and nodule clinic is provided by the Respiratory Specialists and offers diagnosis and management of suspected lung malignancy and surveillance of nodules of concern or lung cancer screening detected nodules.

Associated but separate services at Western Health include:

- Lung Oncology clinics are run by the medical oncology team for patients with DIAGNOSED lung cancers who require systemic treatment (e.g. chemotherapy).
- Thoracic Surgery clinic is run by thoracic surgeons for assessing surgical management.
- Radiation Oncology clinics are run by radiation oncologists for assessment of patients with localized or metastatic cancers requiring radiation therapy.
- SMART clinic is run by palliative care physicians for managing patients with cancer-related symptoms, those not suitable for active treatment or community support.

(Please refer to the relevant referral guidelines for the applicable service)

We aim to review urgent patients within **1-2 weeks**. Further investigations may be ordered prior to clinic review as deemed necessary. If discussion is required, please contact Footscray Respiratory registrar via switch (03 8345 6666) during office hours.

Indefinite referrals *are preferred due to length of surveillance required.*

Conditions for review at Lung Mass and Nodule Clinic:

- Solid Lung nodules >8mm and lung masses >30mm
- Mixed subsolid and solid lung nodule (with solid component >6mm)
- Pure subsolid (or ground glass) nodule >20mm
- Progression of earlier known lung nodule on a serial CT scan
- Positive lung cancer screening imaging (Category 5-High or Category-6 Very High Risk nodules as per standardized reporting)

Conditions not for review at Lung Mass and Nodule Clinic:

- Low risk *incidentally* found nodules to be managed as per Fleischner guidelines (Appendix 1)
- **Low risk nodules** detected in lung cancer *screening* program – primary care follow up as recommended National Lung Cancer Screening Program – Nodule management protocol
- Other lung screening **incidental findings** please refer to relevant clinic referral guidelines or as outlined in NLCSP additional findings guidelines NLCSP Additional Findings Guidelines.pdf

Conditions that require direct referral to the Emergency Department:

- Large volume hemoptysis
- Large Symptomatic Pleural effusions
- Central airway obstruction
- Large lung masses with evidence of metastatic disease and associated symptoms (e.g. severe chest pain)
- Respiratory failure

Access & Referral Priority Lung Mass and Nodule Clinic:

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

URGENT **Appointment timeframe 30 days.**	ROUTINE **Appointment timeframe greater than 30 days, depending on clinical need.**
• Lung nodule(s) ≥ 8 mm • Lung masses ≥ 30 mm • Lung nodules or masses with regional adenopathy or suspected metastatic disease • Multiple thoracic adenopathy with symptoms suspicious for lymphoproliferative disease or atypical infection (e.g. weight loss, night sweats)	• Lung nodules < 8 mm • Thoracic adenopathy without suspicious symptoms for lymphoproliferative disease e.g. granulomatous lung disease

Condition Specific Referral Guidelines:

Key information enables Western Health to triage patients to the correct category and provide treatment with fewer visits to specialist clinics, creating more capacity for care. If key information is missing, you may be asked to return the referral with the required information.

Condition:	Key Information Points:	Clinical Investigations:

Lung nodule(s) or lung **mass(es) suspicious for malignant disease**	• Description of onset, nature, progression, recurrence and duration of symptoms e.g. hemoptysis, chest pain
	• Smoking history (cigarettes and all forms of tobacco, nicotine, vaping, and cannabis)
	• Previous cancer or cancer-screening history (if applicable)
	• Current and complete medication history
	• Past medical history and comorbidities
	• Details if family history of lung cancer
		• **Current imaging reports (e.g. CXR and CT chest) with**
		  ○ **Imaging provider information**
		  ○ **Date**
		• Any previous imaging reports
		• Recent general pathology (if available)
		• Spirometry (if available at practice, or if available within 6 months)

Appendix 1:

2017 Fleischner Society Pulmonary Nodule Follow-Up Guidelines and Recommendations for Solid, Subsolid and Ground-Glass Lung Nodules Criteria - Radiology Universe Institute

Pulmonary Nodule Size	Lung Nodule Type	Single vs. Multiple	Low Risk Patient	High Risk Patient
< 6mm (< 100mm^3)	Solid	Solitary	No Follow-Up If suspicious morphology or upper lobe location, consider 12-month follow-up.	Optional CT in 12 months
		Multiple	No Follow-Up If suspicious morphology or upper lobe location, consider 12-month follow-up.	Optional CT in 12 months
	Part-Solid (Subsolid)	Solitary	No Follow-Up	
		Multiple	CT in 3 to 6 months. If unchanged, consider CT at 2 and 4 years.	
	Ground-Glass	Solitary	No Follow-Up If suspicious, consider follow-up at 2 and 4 years. If grows or increasingly solid, consider resection.	
		Multiple	CT in 3 to 6 months. If unchanged, consider CT in 2 and 4 years.	
6 to 8mm (100-250mm^3)	Solid	Solitary	CT in 6 to 12 months, then **consider** CT in 18 to 24 months.	CT in 6 to 12 months, then **obtain** CT in 18 to 24 months.
		Multiple	CT in 3 to 6 months, then **consider** CT in 18 to 24 months	CT in 3 to 6 months, then **obtain** CT in 18 to 24 months
	Part-Solid (Subsolid)	Solitary	CT in 3 to 6 months to confirm persistance. If unchanged and solid component below 6mm, CT annually for 5 years. **Persistent part-solid nodules containing a solid componment > 6mm are highly suspicious.**	
		Multiple	CT in 3 to 6 months. Then management based on most suspicious nodule(s).	
	Ground-Glass	Solitary	CT in 6 to 12 months to confirm persistence, then CT every 2 years until 5 years. If grows or increasingly solid, consider resection.	
		Multiple	CT at 3 to 6 months. Then management based on most suspicious nodule(s).	
> 8mm (> 250mm^3)	Solid	Solitary	In 3 months consider either CT, Biopsy, or PET-CT (however, negative PET-CT does not exclude low-grade malignancy, FDG uptake may be underestimated in small nodules < 1cm, or those close to diaphragm)	
		Multiple	CT in 3 to 6 months, then **consider** CT at 18 to 24 months	CT in 3 to 6 months, then **obtain** CT at 18 to 24 months
	Part-Solid (Subsolid)	Solitary	CT in 3 to 6 months to confirm persistance. If unchanged and solid component below 6mm, CT annually for 5 years. **Persistent part-solid nodules containing a solid componment > 6mm are highly suspicious.**	
		Multiple	CT at 3 to 6 months. Then management based on most suspicious nodule(s).	
	Ground-Glass	Solitary	CT in 6 to 12 months to confirm persistence, then CT every 2 years until 5 years. If grows or increasingly solid, consider resection.	
		Multiple	CT at 3 to 6 months. Then management based on most suspicious nodule(s).	

High Risk patients for lung cancer include

- Tobacco smoking.
- Family history of lung cancer.
- Upper pulmonary lobe location of nodule.
- Presence of emphysema.
- Older Age.
- Female gender.

Fleischner Society Recommendations and this table do **NOT** apply to:

- Patients who have a known cancer.
- Immunosuppressed patients.
- Lung cancer screening, which has separate criteria.
- Intra-fissural, perifissural, and subpleural pulmonary nodules. Perifissural lung nodules are usually benign, unless suspicious nodule morphology is present (reference).
    - Spiculated margins.
    - Displacement of the pulmonary fissure.
    - Cancer history.
    - In these cases, follow-up should be considered.

Diameter of lung nodule is the **average** of the short and long axes, rounded to the whole millimetre.