

# **Lung Cancer Screening starts July 2025. What every Tasmanian GP should know.**

**This webinar will start shortly.**

# **Lung Cancer Screening starts July 2025. What every Tasmanian GP should know.**

**Zoom webinar – Wednesday 25 June, 6.30-8:00pm**


# Acknowledgement of traditional owners

We acknowledge the Tasmanian Aboriginal people as the traditional owners and ongoing custodians of the land on which we are meeting today. We pay our respects to Elders past and present.

We would also like to acknowledge Aboriginal people who are joining us today.



# Learning outcomes

- Explain the epidemiological and clinical context of the introduction of the National Lung Cancer Screening Program.
  - Identify appropriate patients to undergo screening and Tasmanian referral pathways.
  - Interpret the radiology reporting and risk stratification of patients and be able to use this to appropriately manage patient care.
  - Discuss the purpose and function of the National Cancer Screening Register.
  - Recognise how to integrate general practice software with the National Cancer Screening Register to electronically access and submit patient screening data.
- 

# Some housekeeping

- Tonight's webinar is being recorded
- Please use the Zoom Q&A feature to ask questions
- At the end of the webinar your browser will automatically open an evaluation survey. We appreciate you taking the time to complete this to help us improve our events programme
- Please don't forget to register for your next webinar at:  
<https://www.primaryhealthtas.com.au/for-health-professionals/events/>

# Presenters



**Dr Meg Creely**  
**GP & Clinical Editor**



**Dr Robin Harle**  
**Radiologist**



**John Lee**  
**National Cancer  
Screening Register**

# How do I as a GP approach the National Lung Cancer Screening Program?

**Dr Meg Creely**

**GP & Clinical Editor**

# Why is this happening?

## What the population benefit?

- First new cancer screening program in nearly 20 years
- Leading cause of cancer related deaths in Australia – esp ATSI
- Just under half of lung cancers are diagnosed at stage 4 and significantly different 5 year survival rates between stages
- Aiming to detect lung cancer early to improve mortality and enhance chances of cure
- Aims
  - Reduce mortality from lung cancer
  - Smoking cessation
  - Target high risk populations

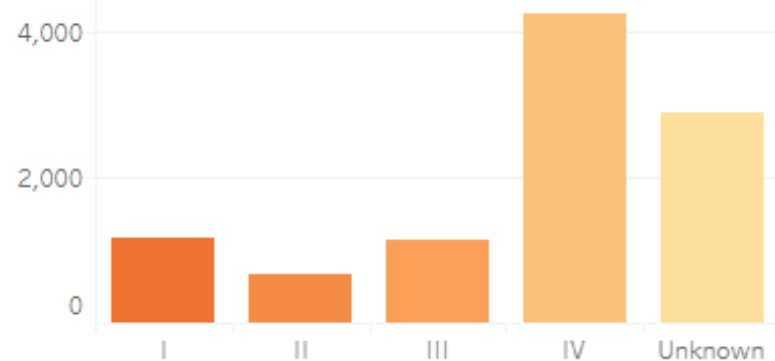


## Incidence

Lung cancer (C33-C34), 2011

Number of cases, by stage at diagnosis

Lung cancer, Persons

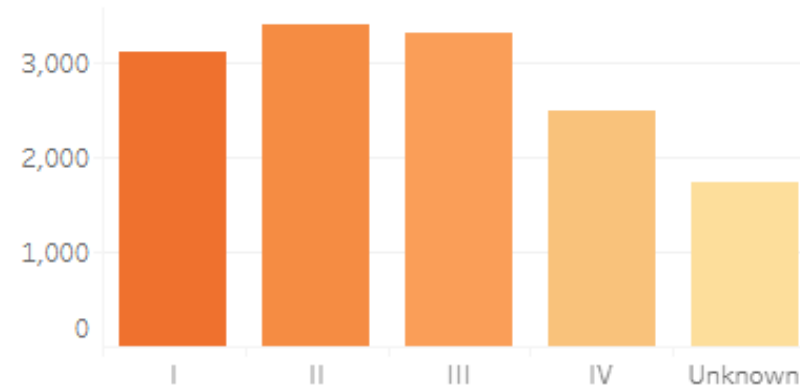


## Incidence

Colorectal cancer (C18-C20), 2011

Number of cases, by stage at diagnosis

Colorectal cancer, Persons

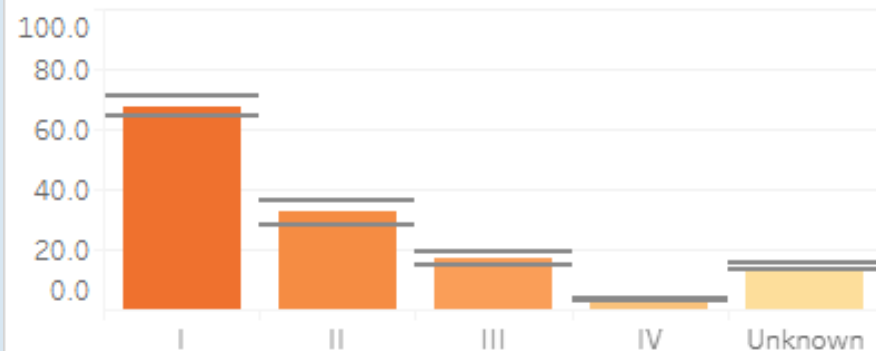


## Survival

Lung cancer (C33-C34), 2011-2016

5-year relative-survival, by stage at diagnosis

Lung cancer, Persons

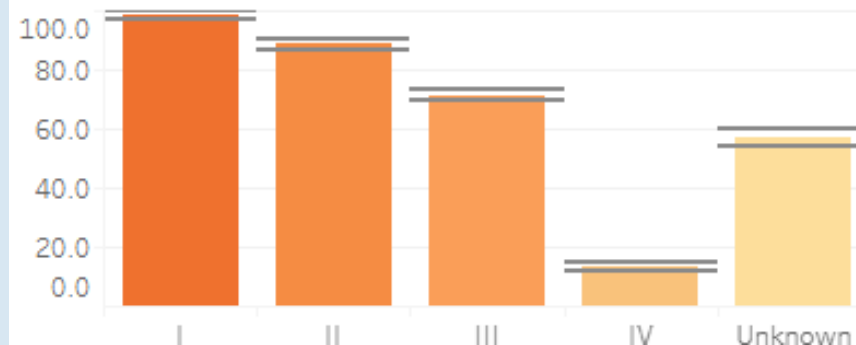


## Survival

Colorectal cancer (C18-C20), 2011-2016

5-year relative-survival, by stage at diagnosis

Colorectal cancer, Persons



# The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812

AUGUST 4, 2011

VOL. 365 NO. 5

## Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening

The National Lung Screening Trial Research Team\*

### ABSTRACT

#### BACKGROUND

The aggressive and heterogeneous nature of lung cancer has thwarted efforts to reduce mortality from this cancer through the use of screening. The advent of low-dose helical computed tomography (CT) altered the landscape of lung-cancer screening, with studies indicating that low-dose CT detects many tumors at early stages. The National Lung Screening Trial (NLST) was conducted to determine whether screening with low-dose CT could reduce mortality from lung cancer.

#### METHODS

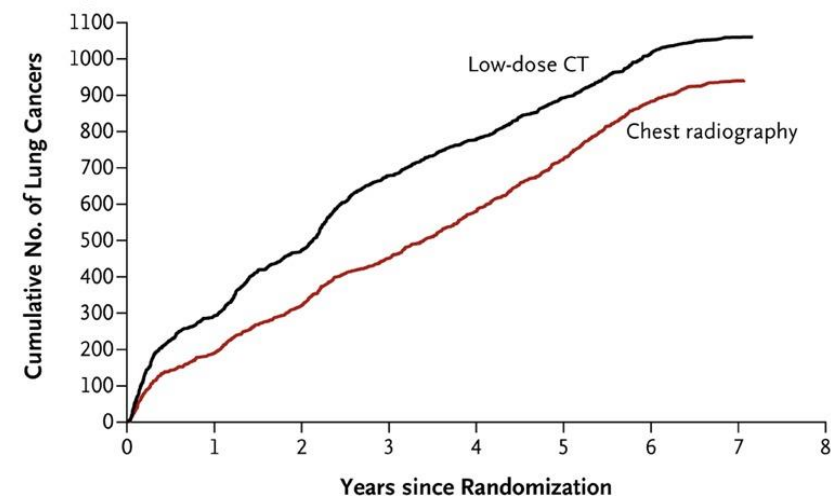
From August 2002 through April 2004, we enrolled 53,454 persons at high risk for lung cancer at 33 U.S. medical centers. Participants were randomly assigned to undergo three annual screenings with either low-dose CT (26,722 participants) or single-view posteroanterior chest radiography (26,732). Data were collected on cases of lung cancer and deaths from lung cancer that occurred through December 31, 2009.

The members of the writing team (who are listed in the Appendix) assume responsibility for the integrity of the article. Address reprint requests to Dr. Christine D. Berg at the Early Detection Research Group, Division of Cancer Prevention, National Cancer Institute, 6130 Executive Blvd., Suite 3112, Bethesda, MD 20892-7346, or at [bergc@mail.nih.gov](mailto:bergc@mail.nih.gov).

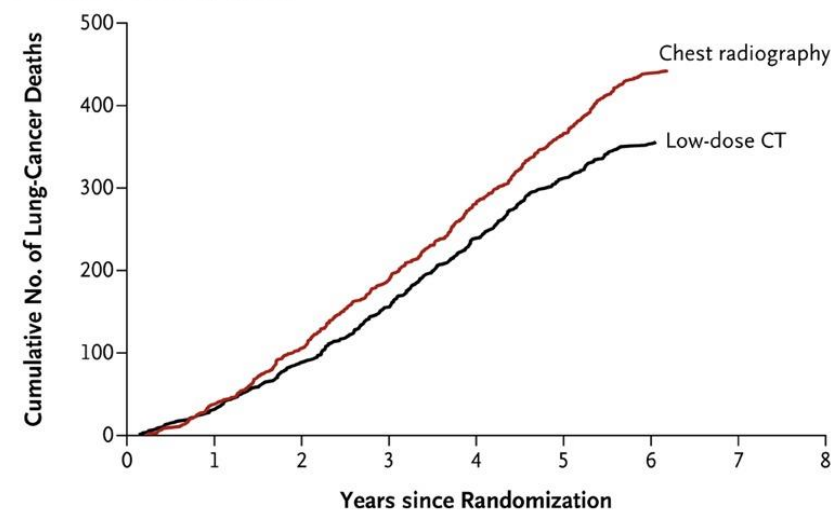
\*A complete list of members of the National Lung Screening Trial research team is provided in the Supplementary Appendix, available at [NEJM.org](http://NEJM.org).

This article (10.1056/NEJMoa1102873) was published on June 29, 2011, at [NEJM.org](http://NEJM.org).

### A Lung Cancer



### B Death from Lung Cancer



# The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812

FEBRUARY 6, 2020

VOL. 382 NO. 6

## Reduced Lung-Cancer Mortality with Volume CT Screening in a Randomized Trial

H.J. de Koning, C.M. van der Aalst, P.A. de Jong, E.T. Scholten, K. Nackaerts, M.A. Heuvelmans, J.-W.J. Lammers, C. Weenink, U. Yousaf-Khan, N. Horeweg, S. van 't Westeinde, M. Prokop, W.P. Mali, F.A.A. Mohamed Hoessein, P.M.A. van Ooijen, J.G.J.V. Aerts, M.A. den Bakker, E. Thunnissen, J. Verschakelen, R. Vliegenthart, J.E. Walter, K. ten Haaf, H.J.M. Groen, and M. Oudkerk

### ABSTRACT

#### BACKGROUND

There are limited data from randomized trials regarding whether volume-based, low-dose computed tomographic (CT) screening can reduce lung-cancer mortality among male former and current smokers.

#### METHODS

A total of 13,195 men (primary analysis) and 2594 women (subgroup analyses) between the ages of 50 and 74 were randomly assigned to undergo CT screening at T0 (baseline), year 1, year 3, and year 5.5 or no screening. We obtained data on cancer diagnosis and the date and cause of death through linkages with national registries in the Netherlands and Belgium, and a review committee confirmed lung cancer as the cause of death when possible. A minimum follow-up of 10 years until December 31, 2015, was completed for all participants.

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Address reprint requests to Dr. de Koning at the Department of Public Health, Erasmus MC—University Medical Center Rotterdam, Doctor Molewaterplein 40, 3015 GD, Rotterdam, the Netherlands, or at h.dekoning@erasmusmc.nl.

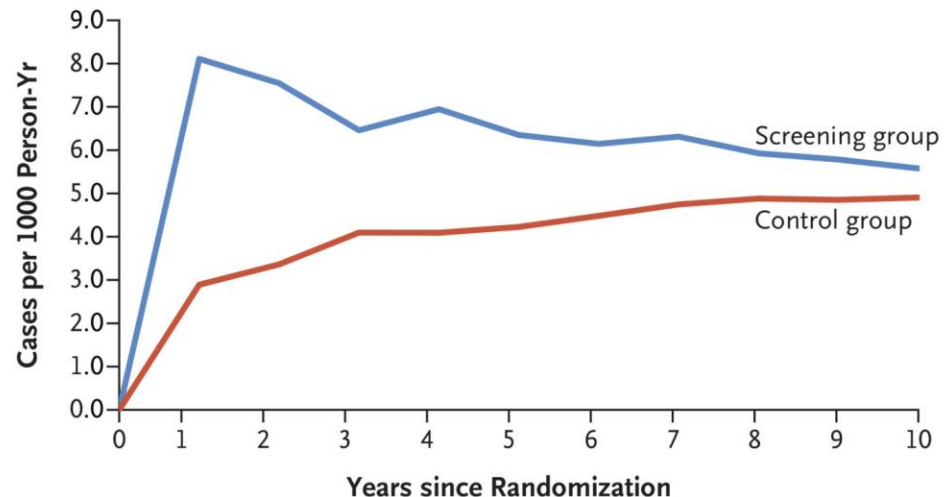
This article was published on January 29, 2020, at NEJM.org.

N Engl J Med 2020;382:503-13.

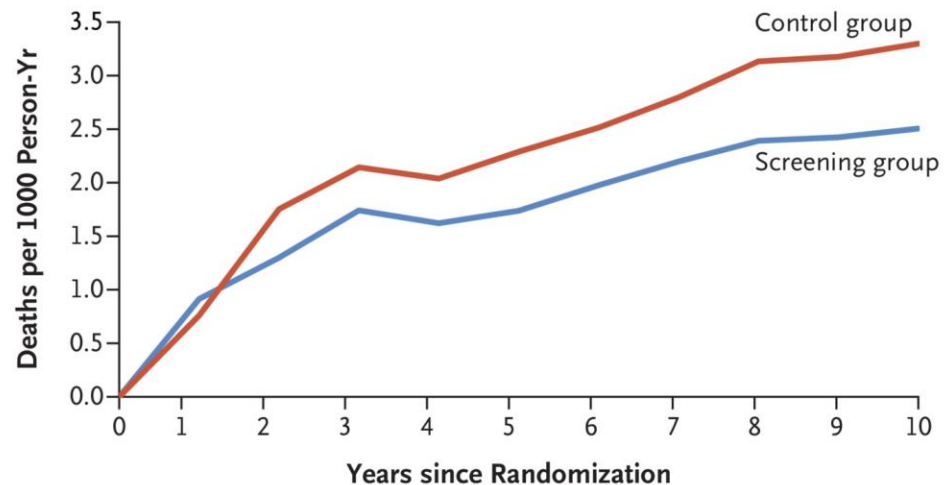
DOI: 10.1056/NEJMoa1911793

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### A Lung-Cancer Incidence



### B Lung-Cancer Mortality



# Eligibility



Are aged 50 to 70 years

AND



Have no symptoms or signs  
that suggest lung cancer

(for example, unexplained persistent cough,  
coughing up blood, shortness of breath  
for no reason)

AND



Smoke tobacco cigarettes  
or have a history of  
cigarette smoking

(having quit within 10 years)

AND



Have a history of tobacco  
cigarette smoking of at least  
30 pack-years

(for example, a pack a day for 30 years,  
or 2 packs a day for 15 years)

# Suitability

## **Assess low-dose CT scan suitability**

Screening may not be suitable for your patient. Plan with your patient when they can re-check their suitability and encourage future participation.

### **Examples of a participant not being suitable include:**

- They have had a full chest CT scan within the last 12 months or have one planned for clinical reasons in the next 3 months.
- They have had a symptomatic lung infection (for example, COVID-19, pneumonia, acute bronchitis) within the previous 12 weeks.
- They are unable to lie flat for a minimum of 5 minutes and hold their hands above their head for a low-dose CT scan.
- Their weight exceeds the restrictions of the scanner (greater than 200 kg). Healthcare providers and/or program participants can check suitability with the radiology provider.



3/06/2025

Laboratory:

☐ Plain X-Ray
 ☐ Special X-Ray
 ☐ Ultrasound
 ☐ Duplex ultrasound
 ☒ CT
 ☐ MRI
 ☐ Mammography
 ☐ Bone densitometry
 ☐ Nuclear medicine
 ☐ User defined

☐ Left
 ☐ Right

Region

Abdomen  
Adrenal glands  
Arthrogram - knee  
Arthrogram - shoulder  
Brain  
Cervical spine  
Chest  
Head  
Kidneys  
Liver  
Lumbar spine  
Lung

Other region:

Add

Clinical details


? Avascular necrosis  
? Bowel obstruction  
? Cholelithiasis  
? Crush fracture  
? Discitis  
? Dislocation  
? Fracture  
? Greater trochanteric bursitis  
? Impingement syndrome

Requests to be printed on form:

Other test:

Details to be printed on form:

NATIONAL LUNG CANCER  
SCREENING PROGRAM  
IMAGING REQUEST



NATIONAL  
LUNG CANCER  
SCREENING  
PROGRAM

The low-dose CT (LDCT) scan is fully funded under Medicare however your doctor may charge a consultation fee for the request and any follow up required.

Patient Details (or affix label)

Patient name:

Address:

DOB:
/
/
Phone:

Medicare number:
MBI

Aboriginal/Torres Strait Islander origin:

☐ No
 ☐ Yes, Aboriginal
 ☐ Yes, Torres Strait Islander
 ☐ Yes, both Aboriginal and Torres Strait Islander
 ☐ Prefer not to answer

Clinical Information

☐ This patient meets the eligibility criteria of the National Lung Cancer Screening Program

Type of screening test:

☐ 2 yearly scan:

☐ New participant
 OR
 ☐ Participant returning for two-year scan

OR

☐ Interval scan to monitor previous findings  
(1,2,3, 6 or 12 month interval scan as determined in previous NLCSP LDCT report)

☐ Any previous chest CT
Date (if known):
/
/

Radiology provider/location (if known):

☐ Family history of lung cancer in a first-degree relatives (only required for first/baseline LDCT)  
(First-degree relatives include parents, siblings or children)

History of any cancer
☐ No
☐ Yes (if yes, provide details)

Additional clinical / other notes, if required

Requesting Practitioner (or affix label)

Name:

Provider Number:

Address:

Phone:
Fax:

Signature:
Date:
/
/

Send copy to:

# Where to send?

Tasmania

Community HealthPathways

Tasmania

Pathology Requests

Medical Imaging Requests

Bone Density Scan (DXA)

Bone Isotope Scan

Breast Imaging

MRI

Neuroimaging Decision Support

Ultrasound Pregnancy

Spirometry

Legal and Ethical

Lifestyle and Preventive Care

Medical

Search HealthPathways

Investigations

Medical Imaging Requests

Medical Imaging Requests

Clinical editor's note

National Lung Cancer Screening using low dose CT is available from 1st July 2025 at the following locations:

South:

• QScan North Hobart

• I-Med Radiology (all)

• Radiology Tasmania

North:

• IMPACT radiology

• I-Med St Vincent's and St Luke's

• Radiology Tasmania











# How to refer to Quitline 13 7848

- ❑ via secure online delivery through website:  
<https://www.quittas.org.au/resources-professionals/quitline-referral-form/>
- ❑ **Fax/fax to email via 6169 1941**
- ❑ Make a referral at <https://aupd.healthlink.net/login.php>  
Type 'Quit Tasmania' in the search bar
- ✓ Email acknowledgement of received referral
- ✓ Referrer feedback provided at cessation of support sessions or if unable to make contact with patient after a number of attempts



# REQUESTING PRACTITIONER FLOW CHART FOR ELIGIBILITY AND CT SCAN REFERRAL

The National Lung Cancer Screening Program (NLCSP) is a targeted screening program available for eligible people aged between 50 and 70 who smoke tobacco cigarettes or have quit smoking within the last 10 years.

Screening regularly with low-dose computed tomography (CT) scans is the best way to detect lung cancer early.

Consider the cultural perspective of each patient you see before talking about lung cancer screening.

Consider involving Aboriginal and Torres Strait Islander Health Practitioners and Aboriginal and Torres Strait Islander Health Workers where possible when speaking with a patient who identifies as an Aboriginal and/or Torres Strait Islander person. Consider accessing [interpreter services](#) for culturally and linguistically diverse people.



Australian Government

NATIONAL  
LUNG CANCER  
SCREENING  
PROGRAM

## 1 Get your practice ready

## 2 Eligibility assessment appointment

## 3 The low-dose CT scan

## 4 Refer or recall for investigation

## 5 Requesting practitioner follow-up and rescreening

### A Complete the checklist to get your practice ready

[Get Your Practice Ready for the National Lung Cancer Screening Program](#)

### B Complete the lung cancer screening eLearning Education modules

### C Check practice records and send invitations

### A Confirm eligibility\*

- Aged 50 to 70 years, and
- Have no symptoms or signs that suggest lung cancer\*\* (for example, unexplained persistent cough, coughing up blood, shortness of breath for no reason), and
- Smoke tobacco cigarettes or have a history of cigarette smoking (having quit within 10 years), and
- Have a history of tobacco cigarette smoking of at least 30 pack-years (for example, a pack a day for 30 years, or 2 packs a day for 15 years).

### B Assess low-dose CT scan suitability

Screening may not be suitable for your patient. Plan with your patient when they can re-check their suitability and encourage future participation.

**Examples of a participant not being suitable include:**

- They have had a full chest CT scan within the last 12 months or have one planned for clinical reasons in the next 3 months.
- They have had a symptomatic lung infection (for example, COVID-19, pneumonia, acute bronchitis) within the previous 12 weeks.
- They are unable to lie flat for a minimum of 5 minutes and hold their hands above their head for a low-dose

### C Participate in shared decision-making to decide together if screening is right for them

Provide shared decision-making for lung cancer screening pamphlet to patients.

[Shared decision-making materials](#)

### D Provide the participant with the NLCSP privacy information notice\*\*\*

### E Complete the Eligibility and Enrolment Form to enrol a participant in the program

Healthcare providers need to complete the form and enrol a participant in the National Lung Cancer Screening Register (NCSR) either through the NCSR interface integrated with clinical software or through the NCSR Healthcare Provider Portal.

[NLCSP Low-dose CT Scan Request Form Healthcare Provider Portal](#)

All participants need a request for screening. Complete a low-dose CT scan request form including information that the scan is for the program and if the participant has a first-degree family history of lung cancer.

### F Provide smoking cessation advice and support

People do not have to quit smoking to participate in the program. Encourage and support the participant to quit smoking; if appropriate, follow the Ask, Advise, Help model.

### A Schedule appointment

The participant will need to book an appointment at a radiology clinic or at a mobile screening service provided in some rural and remote areas; tell the clinic that they are lung cancer screening participant.

### B During the scan

The scan process will take 5 to 10 minutes

It is not painful and no injections are needed

### C After the scan

The radiologist reads and reports the scan using the [NLCSP nodule management protocol](#)

### D The low-dose CT scan report is sent to the NCSR.

### E Results, including recommended actions, are provided to the requesting practitioner by the NCSR and via usual means.

Scan results will be classified into the following categories:

Category	Category descriptor
0	Incomplete
1	Very low risk
2	Low risk
3	Low to moderate risk

### A If a lung nodule or finding not related to lung cancer is found, the participant may need investigation, which could include additional low-dose CT scans, referrals or tests. These will be reported in the radiology report, with guidance regarding next steps provided.

### B If nodules are identified

Investigations of identified nodules may include additional interval low-dose CT scans (at 3, 6 or 12 months) or referral to a respiratory physician linked to a lung cancer multidisciplinary team (MDT).

See [NLCSP nodule management protocol](#)

### C If actionable additional findings are identified

Imaging of the chest may identify actionable additional findings not related to lung cancer.


If actionable additional findings are detected, discuss these with the participant and manage them as per the Royal Australian and New Zealand College of Radiology Actionable Additional Findings Guidelines for the National Lung Cancer Screening Program. This may include referral to other specialists with relevant expertise who are linked with a lung cancer MDT.


See [actionable additional findings guidelines](#)

### Additional notes

\* Once an individual is participating in the program, their smoking history eligibility criteria does not need to be re-assessed.

# Resources

 Tasmania

 Community HealthPathways

Tasmania

Cancer Immunotherapy Side-effects

Cancer Supportive Care

Cancer Therapy Induced Diarrhoea

Chemotherapy and Infection

Chemotherapy-induced Nausea and Vomiting

Corticosteroid Use in Oncology

Established Malignant Melanoma

Gastro-oesophageal Cancer – Established

High Grade Gliomas

Lung Cancer Screening

Pancreatic Cancer – Established

Primary Hepatobiliary Cancer

Spinal Cord Compression

Oncology Requests

Pain Management

Palliative Care

Rehabilitation Medicine

Respiratory

Rheumatology

Sexual Health

lung sc

Medical / Oncology / Lung Cancer Screening

## Lung Cancer Screening

See also:

- [Lung Cancer – Suspected](#)
- [Smoking and Vaping Cessation](#)

**Clinical editor's note**

The National Lung Cancer Screening Program commences 1 July 2025. The relevant MBS items for low-dose CT scans (accessible by radiologists) for general practitioner referrals will not be active until this time.

### Background

[About lung cancer screening](#)

### Assessment

- Take a [history](#). If any signs or symptoms suggestive of lung cancer, follow the [Lung Cancer – Suspected](#) pathway.
- Consider [potentially underscreened priority populations](#).
- Be aware of possible [stigma attached to smoking](#) and ensure that the consultation is not influenced by it.
- Assess the patient's [eligibility](#) for baseline (first) lung cancer screening.
- Check [previous lung cancer screening history](#).
- If eligible for screening, assess the patient's [suitability for low-dose CT scan of the chest](#).
- Consider [functional status and co-morbidities](#) when considering lung cancer screening.

SEND FEEDBACK

# National Lung Cancer Screening Program – resources for the health sector



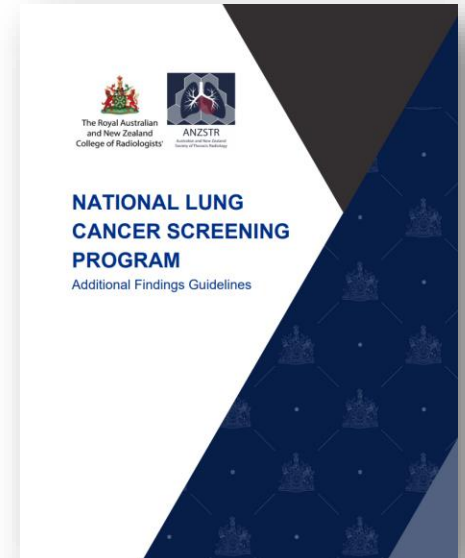
**Program guidelines**  
Healthcare providers



**eLearning modules**  
Healthcare providers

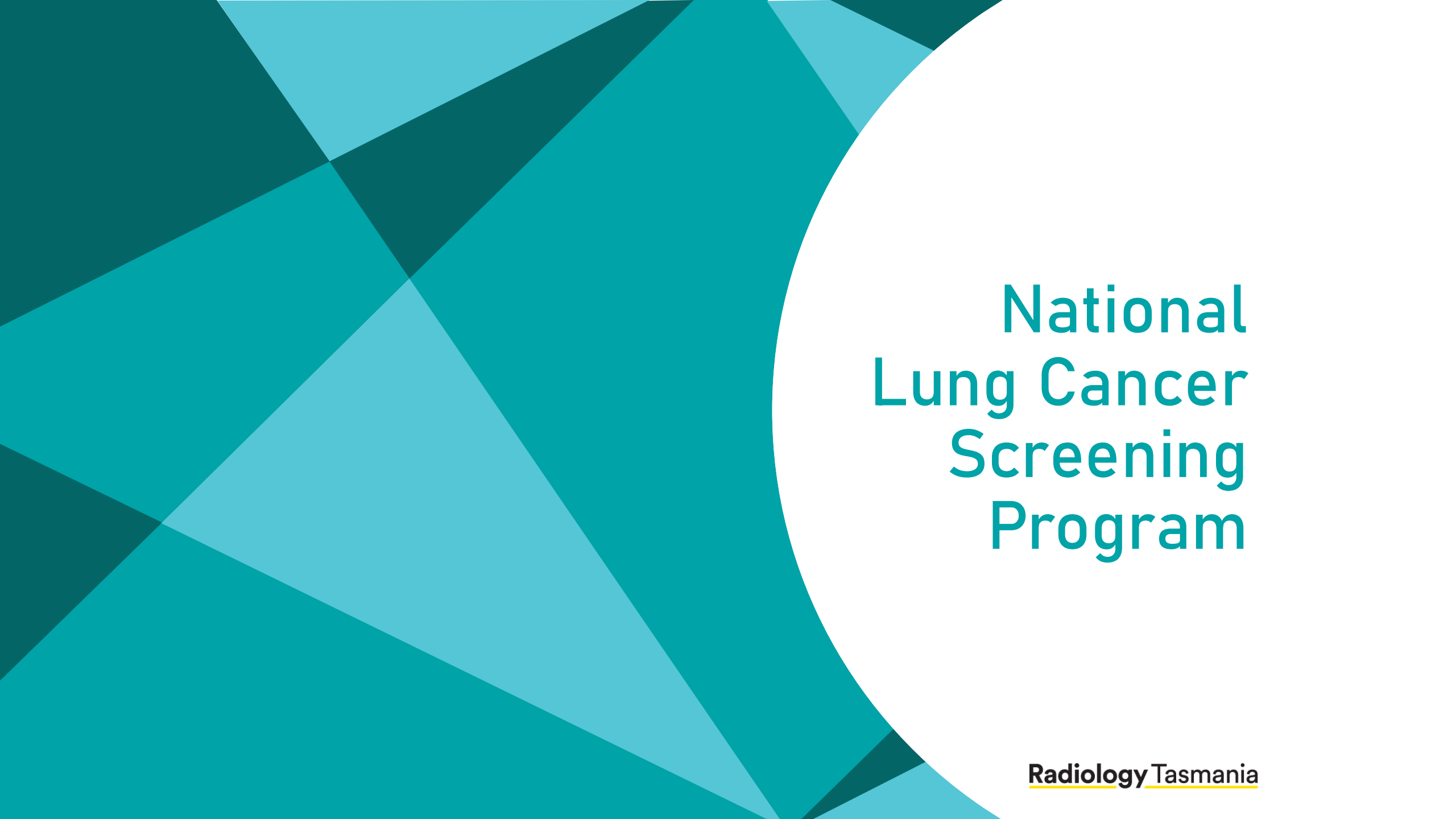


**Information materials**  
Consumers &  
healthcare providers



**Guidance, education  
& training**  
Radiology sector

**More information: [health.gov.au/nlcsp](https://health.gov.au/nlcsp)**



# National Lung Cancer Screening Program

**Radiology Tasmania**

# What is the NLCSP?

- First new imaging-based screening program in Australia since breast screen
- 2 yearly screening of high-risk patients with non-contrast, low dose thoracic CT scan
- This is not copying overseas programs!
- Developed for Australian Health Services



# Why do we think 2 years safe?

- We have learnt from the other screening programs!
- 1<sup>st</sup> round using probability of nodule being a lung cancer
  - <1.5% returns to 2 yearly follow up
- 2nd and further rounds based on growth of nodule
- Based on volumetric analysis if possible

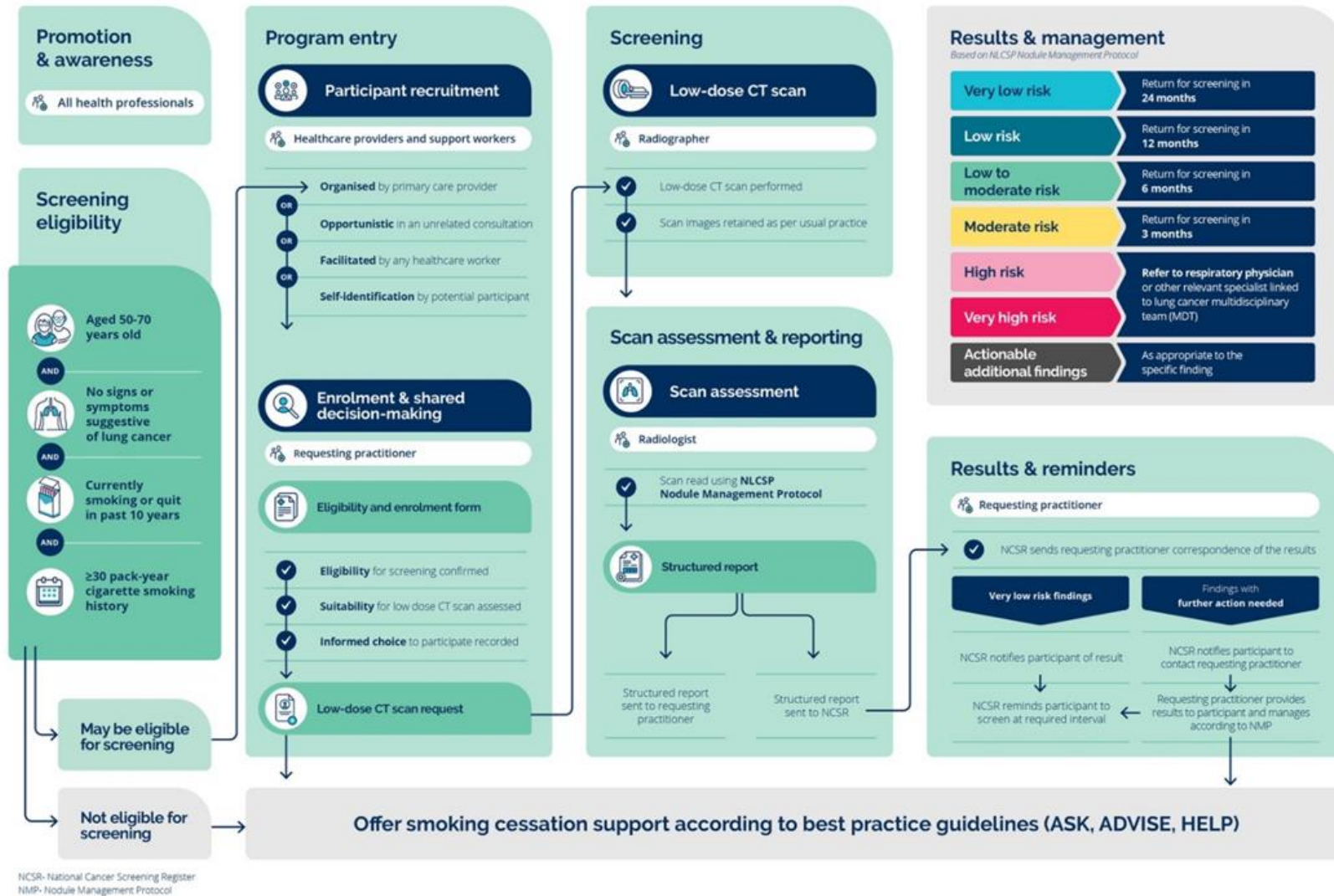
# Who is eligible?

- 50 – 70 years old
- Asymptomatic (no signs/ symptoms suggestive of lung cancer)
- 30 pack/year smoking history
- Current smoker or ceased in last 10 years
- Suitable for non-contrast CT scanning

# Unsuitability for Low Dose CT

- Weight > restrictions of scanner (>200kg – varies with scanner)
- Unable to lie flat for a minimum of 5 minutes
- Symptomatic lung infection within the previous 12 weeks
- Full CT scan of the chest within last 12 months or planned for clinical reasons, in the next 3 months (eg active cancer surveillance)

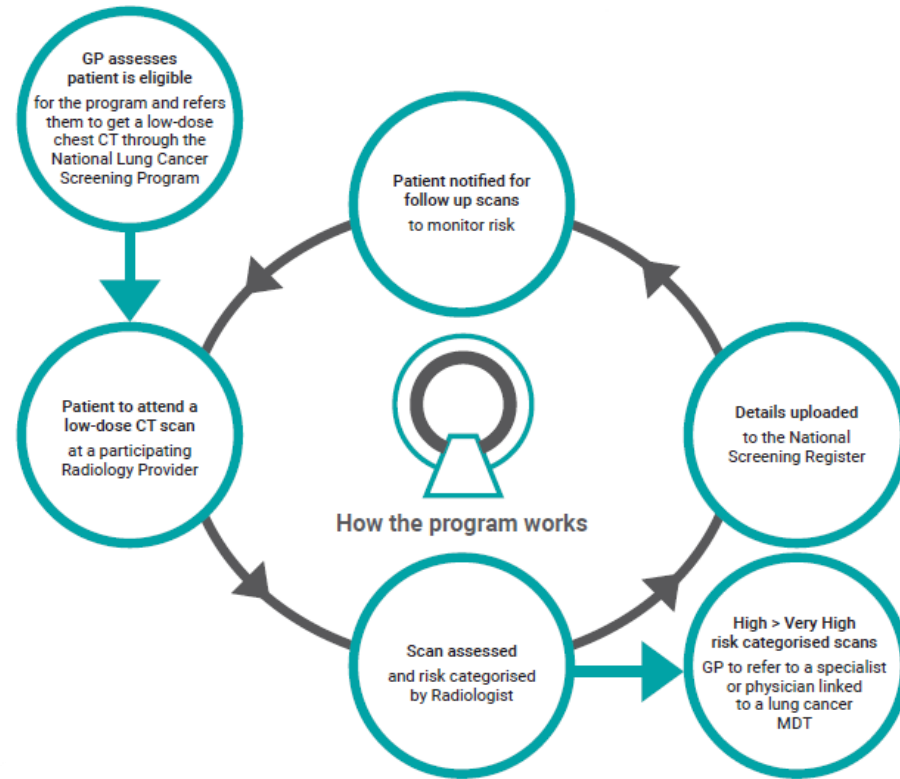
# Screening and Assessment Pathway



# The Patient Journey – A High Level Overview



# The Patient Journey



# Medicare Items & Booking Codes

## New Items

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There are two new medicare items that have been introduced to support the administration of the NCLSP. It is important our teams familiarise themselves with these codes and when each should be applied.

Patients can be referred by GP's, Specialists, Consultants and Nurse Practitioners for these items and they are always bulk billed.

### 57410 – Screening low dose CT Scan (RIS: CTCLS)

Low-dose computed tomography (low-dose CT) scan of chest for the National Lung Cancer Screening Program, without intravenous contrast medium, where:

- the request states that the patient's eligibility to participate in the National Lung Cancer Screening Program has been assessed and confirmed; and
- the service utilises the agreed nodule management protocol for standardised lung nodule identification, classification and reporting; and
- the service is bulk-billed. (R) (Anaes.)

**Can be used once every two years**

### 57413 – Interval Low Dose CT Scan (RIS: CTCLSS)

Low-dose computed tomography (low-dose CT) scan of chest for the National Lung Cancer Screening Program, without intravenous contrast medium, where:

- the service is:
  - (a) performed as a clinical follow-up within 2 years of a screening low-dose CT scan of MBS item 57410; or
  - (b) performed as a clinical follow-up to a previous interval low-dose CT scan of MBS item 57413 linked to MBS item 57410; and
- the service utilises the agreed nodule management protocol for standardised lung nodule identification, classification and reporting; and
- the service is bulk-billed (R) (Anaes.)

# Medicare Items & Booking Codes

## New Items – Plain Language Explanation

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### 57410 – Screening low dose CT Scan (RIS: CTCLS)

As part of the NLCSP, eligible individuals will receive a Screening Low Dose CT (LDCT) every two years. This scan marks the beginning of each two-year screening cycle.

Only one Screening LDCT is permitted within each two-year screening round

As the NCSR generally sends screening reminders 3 months prior to the commencement of a new screening round, the individual may present early following receipt of the screening reminder.

This item may be claimed for service rendered within the 3 month period prior to commencement of the 2 year screening round.

### 57413 – Interval Low Dose CT Scan (RIS: CTCLSS)

Following the Screening LDCT, some individuals will require repeat LDCT imaging at 12 months (low risk), 6 or 3 month (moderate risk) intervals

This is the item number used for those patients.

This item number will only work for patients who have item 57410 billed to Medicare within the past 2 years



# Referral

- Must specify that it is for the NLCSP and include family history of lung cancer in any 1<sup>st</sup> degree relative, details of any previous chest CT (if known) and history of any cancer

# Imaging Requests

1

## **Chest Scan Request Form**

Some referrers will opt to use our new 'Chest Scan' branded referrals, which will be distributed by MLO's



2

## **NLCSP Request Form**

The NLCSP also has a template request form on the program website





3

## **Standard Request forms**

The program allows the use of all standard imaging request forms, including branded and plain paper request forms

# Imaging Requests – NLCSP & Chest Scan Examples

**NATIONAL  
LUNG CANCER  
SCREENING  
PROGRAM**

**chest scan  
AUSTRALIA**

referral form

Name

Address

Email

D.O.B.

Phone

Medicare No.

PATIENT DETAILS

☐ ELIGIBLE FOR NLCSP LOW DOSE CHEST CT

☐ NLCSP Follow-up Scan

☐ Asymptomatic

☐ Age 50 - 70 years

☐ Current Smoker – 30 pack-year


☐ Ex-smoker – 30 pack-year smoking history who has quit within the last 10 years

ELIGIBILITY

Doctor

CLINICAL NOTES

**NATIONAL LUNG CANCER  
SCREENING PROGRAM  
IMAGING REQUEST**

**NATIONAL  
LUNG CANCER  
SCREENING  
PROGRAM**

The low-dose CT (LDCT) scan is fully funded under Medicare however your doctor may charge a consultation fee for the request and any follow up required.

Patient Details (or affix label)

Patient name:

Address:

DOB: / / Phone:

Medicare number: MBI

Aboriginal/Torres Strait Islander origin:

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Prefer not to answer

Clinical Information

☐ This patient meets the eligibility criteria of the National Lung Cancer Screening Program

Type of screening test:

☐ 2 yearly scan: ☐ New participant OR ☐ Participant returning for two-year scan

OR

☐ Interval scan to monitor previous findings  
(1,2,3, 6 or 12 month interval scan as determined in previous NLCSP LDCT report)

☐ Any previous chest CT Date (if known): / /

Radiology provider/location (if known):

☐ Family history of lung cancer in a first-degree relatives (only required for first/baseline LDCT)  
(First-degree relatives include parents, siblings or children)

History of any cancer ☐ No ☐ Yes (if yes, provide details)

# Radiology in the NLCSP

We anticipate that:

- Majority of CTs will be performed in private practice
- Fairly slow ramp up of numbers
- ?? 200-250k extra CT chest scans per year nationally

have subspecialty training in chest

- 88% of radiologists perform at least some general work



Workforce implications:

- 73% of radiologists work at least part time in private practice
- Only 5% of radiologists

# Radiologist Role

	Program entry and supporting choice	Low-dose CT scan and reporting	Management of results, follow-up and reminders
<b>Radiologists</b>	-	Read and assess low-dose CT scan Complete structured radiology report	Access program participant low-dose CT screening histories from NCSR as needed Send report to the NCSR Send report to requesting practitioner
<b>Radiographers</b>	-	Perform low-dose CT scan	-

# Radiologist

- Reports scan
- Structured report for National Cancer Screening Register
- Assess for pulmonary nodules/masses
- Atypical lung cysts
- Airway nodules
- Additional Findings

# Baseline

- Determine risk of cancer based on Brock modelling (PanCan)

# PanCan Nodule Malignancy Risk Calculator

Optimised selection of  
low- and high-risk categories:

75.2% to 24m LDCT (not 12m)

2.8% cf 7.4% requiring referral

Age  years

Sex ☒ Female (0.6011)  
☐ Male (0)

Family history of lung cancer ☒ (0.2961)

Emphysema ☒ (0.2953)

Nodule size  mm

Nodule type ☐ Nonsolid or ground-glass (-0.1276)  
☐ Partially solid (0.377)  
☒ Solid (0)

Nodule in upper lung ☒ (0.6581)

Nodule count  #

Spiculation ☒ (0.7729)

Log odds

Cancer probability  %

Decimal precision

McWilliams A et al. Triaging ILST screening participants at program entry. Presented at: IASLC World Conference for Lung Cancer, 7-10 September 2024, San Diego USA

Up to Date: Solitary Pulmonary Nodule Malignancy Risk Calculator (Brock University)





# PanCan Nodule Malignancy Risk Calculator

- Optimises selection of low- and high-risk participants at baseline
- Browser-based, downloaded or automated in volumetry software
- % malignancy risk for that nodule

< 1.5%

24-month  
LDCT

1.5 – < 6%

12-month  
LDCT

6 – < 10%

6-month  
LDCT

10 – < 30%

3-month  
LDCT

≥ 30%

MDT  
Referral

$< 1.5\%$

Category 1

24-month  
LDCT

$1.5 - < 6\%$

Category 2

12-month  
LDCT

$6 - < 10\%$

Category 3

6-month  
LDCT

$10 - < 30\%$

Category 4

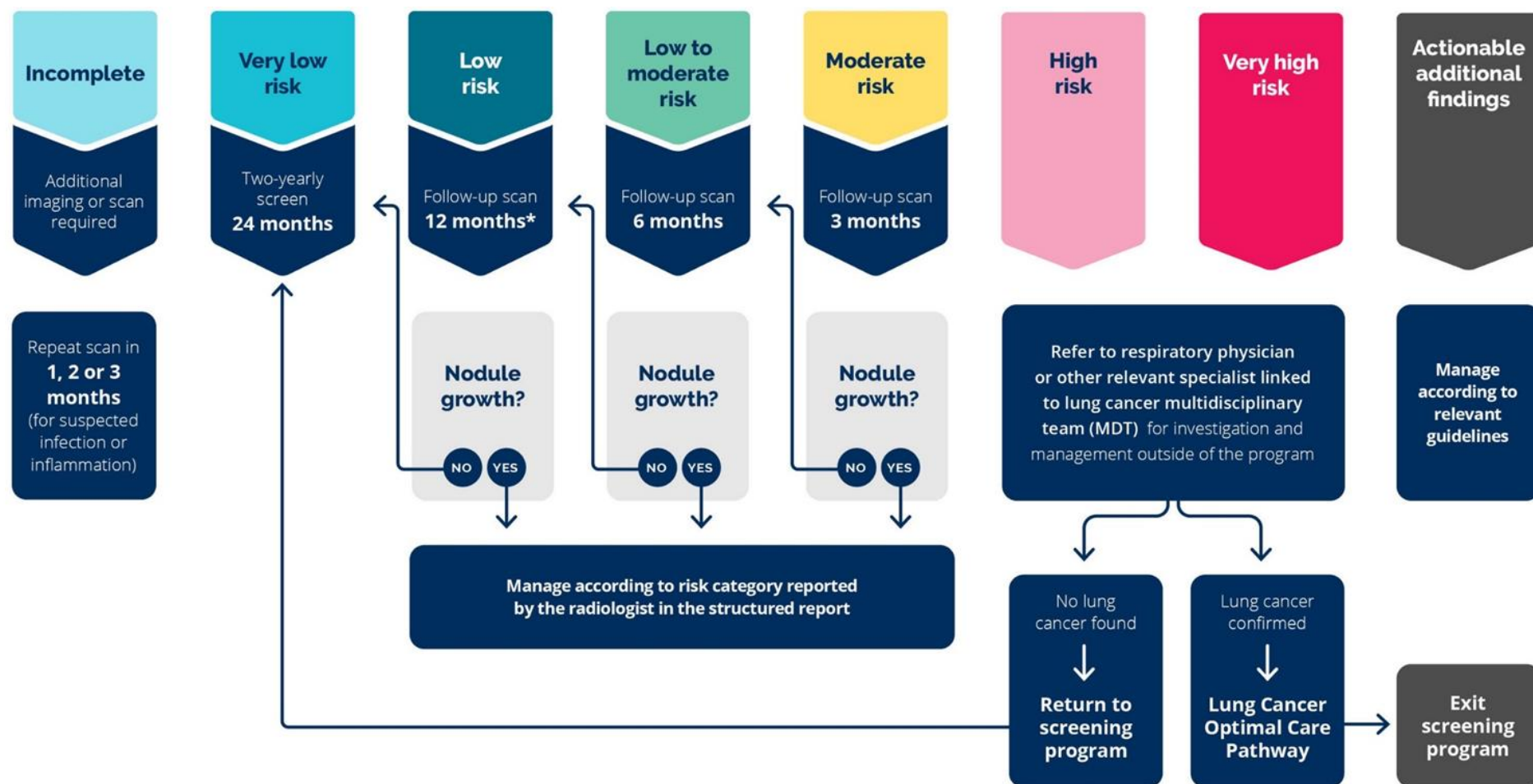
3-month  
LDCT

$\geq 30\%$

Category 5  
Category 6

MDT  
referral

# Results



\*Low risk participants require two 12 month scans before extending to 24 months.

# Results

- Incomplete
- Very Low Risk
- Low Risk
- Low to moderate Risk
- Moderate Risk
- High Risk
- Very High Risk
- Additional Actionable Finding

# Results

## Incomplete

- Part or all of the lung can't be evaluated eg pneumonia
- Follow up in 1, 2 or 3 months time

## Very low risk

- Rescreen in 2 years

## Low Risk

- 12 month follow up

## Low to Moderate Risk

- 6 month follow up

## Moderate Risk

- 3 month follow up

## High Risk

- Refer to respiratory physician and MDM

## Very High Risk

- Significant Radiologist concern
- Refer to respiratory physician and MDM

Category descriptor	Communicating results with participant	Next steps for the participant
Incomplete	The radiologist could not evaluate all or part of the lung due to inflammation or infection. The participant will need to get another scan in 1, 2 or 3 months, depending on the findings.	Continue in program Make an appointment to see the requesting practitioner to obtain a low-dose CT scan request.
Very low risk	The radiologist did not notice anything of concern on the scan. Regular screening is important to check for changes as the participant ages.	Continue in program Receive a reminder for <b>two-yearly</b> repeat screening Make an appointment to see the requesting practitioner to obtain a low-dose CT scan request.
Low risk	The radiologist has noticed one or more small nodules that needs monitoring over time. The participant is considered to have a low chance of lung cancer.	Continue in program Receive correspondence to discuss results with healthcare provider Receive a reminder for a <b>follow-up scan in 12-months</b> Make an appointment to see the requesting practitioner to obtain a low-dose CT scan request.



Category descriptor	Communicating results with participant	Next steps for the participant
Low to moderate risk	The radiologist has noticed one or more nodules on the scan that need to be monitored more frequently.	Continue in program Receive correspondence to discuss results with healthcare provider Receive a reminder for a follow-up scan in 6-months Make an appointment to see the requesting practitioner to obtain a low-dose CT scan request.
Moderate risk	The radiologist has noticed one or more nodules on the scan that need to be monitored more frequently.	Continue in program Receive correspondence to discuss results with healthcare provider Receive a reminder for a <b>follow-up scan in 3-months</b> Make an appointment to see the requesting practitioner to obtain a low-dose CT scan request.
High risk	The radiologist has noticed one or more nodules that need further investigation. This does not mean that the participant has cancer. There is a higher risk of lung cancer, so it is important that the participant attends all follow-ups.	Receive correspondence to discuss results with healthcare provider Healthcare provider organises urgent appointment <b>Referred to a respiratory physician*</b> linked to a lung cancer multidisciplinary team (MDT) Remain in program whilst investigations are underway.

# Results

<b>Very high risk</b>	<p>The radiologist has noticed one or more nodules that need further investigation. This does not mean that the participant has cancer. There is a higher risk of lung cancer, so it is important that the participant attends all follow-ups.</p>	<p>Receive correspondence to discuss results with healthcare provider Healthcare provider organises urgent appointment Referred to a respiratory physician* linked to a lung cancer multidisciplinary team (MDT) Remain in program whilst investigations are underway.</p>
<b>Actionable additional findings</b>	<p>Sometimes the scan can show things either in the lungs (something other than cancer, such as emphysema), or outside of the lungs (something like heart disease).</p>	<p>Receive correspondence to discuss results with healthcare provider Actionable additional findings investigated according to relevant clinical guidelines and usual care arrangements Refer to <a href="#">Actionable additional findings</a> and <a href="#">Program exit and re-entry</a> sections to understand whether the participant will remain in the program or whether they will exit/pause participation.</p>

## Follow up

- Looking for change in volume
- Same provider preferably
  - Each volume program calculates differently – more reliable if same program used

## Follow-up

Category descriptor	Findings	Management	Category
<b>Incomplete</b>	Findings suggestive of an inflammatory or infectious process	1-, 2-, or 3-month LDCT	<b>0</b>
<b>Very low risk</b>	No lung nodules	24-month LDCT	<b>1</b>
	Previous Category 1 lesion that is stable or decreased in size		
	Previous Category 2 lesion that is stable or decreased in size over a period of 24 months or more		
	Nodule with benign features including: <ul style="list-style-type: none"> <li>Complete, central, popcorn, or concentric ring calcifications</li> <li>Fat-containing</li> </ul>		
	Solid nodule: New < 34 mm <sup>3</sup> (< 4 mm)		
	Lesion evident on pre-screening CT imaging, and stable or decreased over more than 24 months (excluding persistent segmental or more proximal airway nodules)		
<b>Low risk</b>	Previous Category 2 lesion that is stable or decreased in size over a period of less than 24 months	12-month LDCT	<b>2</b>
	Previous Category 3 lesion that is stable or decreased in size at 6-month follow-up LDCT		
	Airway nodule, subsegmental – new		
	Juxtapleural nodule: <ul style="list-style-type: none"> <li>New 524 mm<sup>3</sup> (&lt;10 mm) AND</li> <li>Solid; smooth margins; and oval, lentiform, or triangular shape</li> </ul>		
	Non-solid nodule (ground glass): <ul style="list-style-type: none"> <li>&lt; 14,137 mm<sup>3</sup> (&lt; 30 mm): New or growing</li> <li>≥ 14,137 mm<sup>3</sup> (≥ 30 mm): Slowly growing</li> </ul>		
<b>Low to moderate risk</b>	Previous Category 4 lesion (excluding persistent segmental or more proximal airway nodules) that is stable or decreased in size at 3-month follow-up LDCT	6-month LDCT	<b>3</b>
	Atypical pulmonary cyst: <ul style="list-style-type: none"> <li>Growing cystic component (mean diameter) of a unilocular thick-walled cyst</li> </ul>		
	Solid nodule: <ul style="list-style-type: none"> <li>New 34 to &lt; 113 mm<sup>3</sup> (4 mm to &lt; 6 mm)</li> </ul>		
	Part solid nodule: <ul style="list-style-type: none"> <li>New &lt; 113 mm<sup>3</sup> (&lt; 6 mm total mean diameter)</li> </ul>		
	Non-solid nodule (ground glass): <ul style="list-style-type: none"> <li>≥ 14,137 mm<sup>3</sup> (≥ 30 mm) new or growing</li> </ul>		
<b>Moderate risk</b>	Airway nodule, segmental or more proximal - new	3-month LDCT	<b>4</b>
	Atypical pulmonary cyst: <ul style="list-style-type: none"> <li>Newly multilocular cyst that was previously unilocular</li> <li>New atypical pulmonary cyst of any morphology</li> </ul>		
	Solid nodule: <ul style="list-style-type: none"> <li>Growing &lt; 268 mm<sup>3</sup> (&lt; 8 mm) OR</li> </ul>		

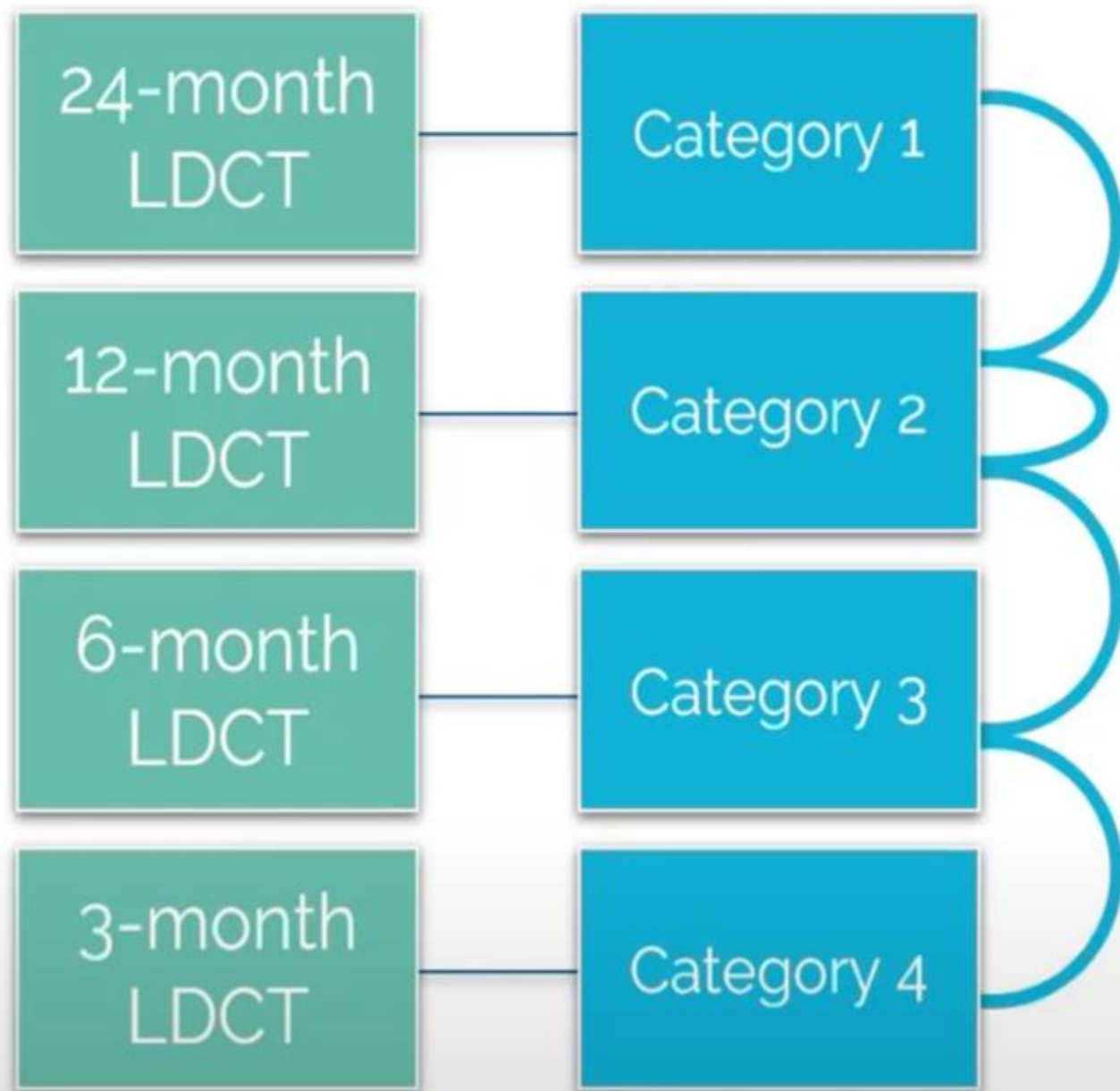
Category descriptor	Findings	Management	Category
High risk	Airway nodule, segmental or more proximal – stable or growing	Refer to Respiratory Physician linked to a lung cancer multidisciplinary team	5
	Atypical pulmonary cyst: <ul style="list-style-type: none"> <li>Thick-walled cyst with growing wall thickness/nodularity OR</li> <li>Growing multilocular cyst (mean diameter) OR</li> <li>Multilocular cyst with increased loculation or new/increased opacity (nodular, ground glass, or consolidation)</li> </ul>		
	Solid nodule: <ul style="list-style-type: none"> <li>New or growing <math>\geq 268 \text{ mm}^3</math> (<math>\geq 8 \text{ mm}</math>)</li> </ul>		
	Part solid nodule: <ul style="list-style-type: none"> <li>New or growing <math>\geq 34 \text{ mm}^3</math> (<math>\geq 4 \text{ mm}</math>) solid component</li> </ul>		
	Slowly growing solid or part solid nodule		
Very high risk	Further features or imaging findings that increase suspicion for lung cancer	Refer to Respiratory Physician linked to a lung cancer multidisciplinary team	6
Actionable additional findings	Clinically significant or potentially clinically significant findings unrelated to lung cancer will be described with appropriate recommendations	As appropriate to the specific finding	A

growing , stable , and decreased based on mean diameter measurement.

6	Definitions of "growing", "slowly growing", "stable, and "decreased"		
		Nodule measurement using volumetry (preferred method)	Nodule measurement using mean diameter (when measurement using volumetry is not possible)
	Growing	Increase greater than 25% and VDT < 600 days	Increase of more than 1.5mm, 24 months or less
	Slowly growing	Increase greater than 25% and VDT >600 days, on more than one scan interval	Increase of more than 1.5mm, over more than 24 months
	Stable	Change between -25% and +25% or increase from baseline greater than 25% and VDT>600 days but not slow growth	Change of between -1.5mm and +1.5mm
	Decreased	Decrease of 25% or more	Decrease of 1.5 mm or more
	<p>Note that the earliest scan available should be used as the comparison study to establish initial change. Unless there is a pre-screening CT available, this will be the baseline NLCSP LDCT.</p> <p>Nodules may undergo change in trajectory, meaning growth followed by stability, or slow growth followed by decrease etc. When there is trajectory change, the scan on which the nodule has <u>last</u> demonstrated the previous trajectory should be used as the new comparison study.</p>		



#	Notes	
7	<b>Prior exams:</b> Comparison to prior imaging is essential for interpretation of LDCT in the NLCSP. Radiologists are advised to review the oldest available CT to ensure slow growth is not missed. Comparison could include review of non-NLCSP CT performed before or between screening LDCT.	
	For stable pulmonary nodules based on comparison to pre-NLSCP CT, a suggested approach is as follows:	
	<b>Any</b> nodule stable for more than 24 months      Assign Category 1	
	<b>Any</b> nodule stable for 9 to 24 months      Assign Category 2	
	If nodule stable for less than 9 months: calculate PanCan risk and assign based on the pre-NLCSP CT as described	If previous Category 1      Assign Category 1
		If previous Category 2      Assign Category 2
		If previous Category 3      Stable for 6 or more months: assign Category 2 Stable for less than 6 months: assign Category 3
If previous Category 4      Stable for 3 or more months: assign Category 3 Stable for less than 3 months: assign Category 4		
If previous Category 5 or 6      Consider referral unless stability is strongly radiologically reassuring		



**If stable at  
follow-up:  
Stepped  
Management**

# Results

- Very Low Risk notified of very low risk findings and to rescreen every 2 years
- All others Notified to contact requesting practitioner
- Referrer notified and to contact the participant for all
- Referrer notified via phone call and correspondence for High and Very High Risk

# Additional Findings

Unfortunately, don't just scan the lungs

See other things

Lungs – non cancer

- Emphysema
- ILA
- Bronchiectasis
- Diffuse Cystic Lung Disease
- Diffuse Nodular Lung Disease

# Additional Findings

## Pleura

- Effusion
- Bilateral calcified pleural plaques

## Mediastinum

- Nodes >15mm
- Mass

# Additional Findings

## Vascular

- Coronary artery calcified plaque
- Aortic valve calcification
- Pericardial effusion
- Thoracic aortic dilatation >45mm
- Pulmonary artery dilatation >32mm or > than aorta



# Additional Findings

## Abdomen

- Liver lesion >10mm, not a simple cyst (HU>20)
- Diffuse liver disease – steatosis, cirrhosis
- Kidney lesion – homogeneous 21-69 HU, or heterogenous
- Adrenal nodule >10mm
- Abdominal Aortic Aneurysm >42mm
- Pancreas mass or cyst >10mm

# Additional Findings

## Breast

- Lesion
- Axillary lymphadenopathy

## Thyroid

- Nodule >15mm or suspicious
- Multinodular goitre

## Bone

- Reduced bone density <100 HU at L1
- Vertebral compression fracture >20% height loss

# Additional Findings

## Recommendations

- Usually clinical review
- Recommendations for further testing/ follow up
- DEXA, Follow up adrenal CT etc
- Recommendations will be verbatim from the guidelines

Aim is not to over investigate/over report

Minor changes will not be reported

# Exit from the Program

- Patient can withdraw at any time
- Age >70
- Cancer diagnosis

# Report

- Structured report
- Not usual report
  - Clinical Notes
  - Study Information
  - Nodule Findings
  - Additional Findings
  - Conclusion

# Example Report

## 1. NLCSP Structured Clinical Radiology Report – Filled Example 1

This example shows a sample NLCSP report completed for a participant with no nodules.

### CLINICAL NOTES

Smoking history. Eligible for lung cancer screening.  
Family history of lung cancer (baseline only): yes

### STUDY INFORMATION

Radiologist HPI-I: 1234567812345678  
Technique: Non-contrast low dose volumetric acquisition of the chest.  
CAD/AI/Volumetry used: CAD X  
CTDIvol (mGy): 1.5  
Scan image quality: adequate  
Comparison CT(s): none



# Example Report

## NODULE FINDINGS

Likely Infection or Inflammation: no

Nodules Considered Benign (excluding the above): no

Pulmonary Nodules for Follow-Up (excluding the above): no

The most significant nodules, up to four, will be listed for follow-up.

Minimum reportable size 34 mm<sup>3</sup> (4.0 mm).

---

## ADDITIONAL FINDINGS

Actionable additional findings from this study: no

## CONCLUSION

Screening Category and Management: Category 1; 24-month LDCT.

Where possible, the participant is recommended to return to the same imaging provider for future studies to facilitate image comparison.

# Example Report - Nodule

## NODULE FINDINGS

Likely Infection or Inflammation: no

Nodules Considered Benign (excluding the above): yes

Description of nodules considered benign: scattered sub 3 mm calcified granulomata

Pulmonary Nodules for Follow-Up (excluding the above): yes

The most significant nodules, up to four, will be listed for follow-up. Minimum reportable size 34 mm<sup>3</sup> (4.0 mm).

---

### Observed Nodule A

Assigned nodule number: 1

Date nodule first visible: 13/02/25

Slice location: series 3, image 47

Anatomical location: RUL

Type: part solid

Spiculation: yes

Maximal axial diameter for PanCan calculation (mm): 10.4 Total volume (mm<sup>3</sup>): 524

Volume, solid component (mm<sup>3</sup>): 360

PanCan risk (% , baseline only): 24

Screening Category (this nodule): 4

# Example Report – Additional Findings

## ADDITIONAL FINDINGS

Actionable additional findings from this study: yes

Lungs: n/a

Pleura: n/a

Mediastinum: n/a

Cardiovascular: n/a

Abdomen: yes. 2.5 cm intermediate density (40 HU) lesion arising from the upper pole of the left kidney.

Thyroid: n/a

Breast: n/a

Bone: n/a

Other: n/a

## CONCLUSION

Screening Category and Management: Category 4; 3-month LDCT.

Actionable Additional Findings Summary: Indeterminate kidney lesion. Refer for renal ultrasound.

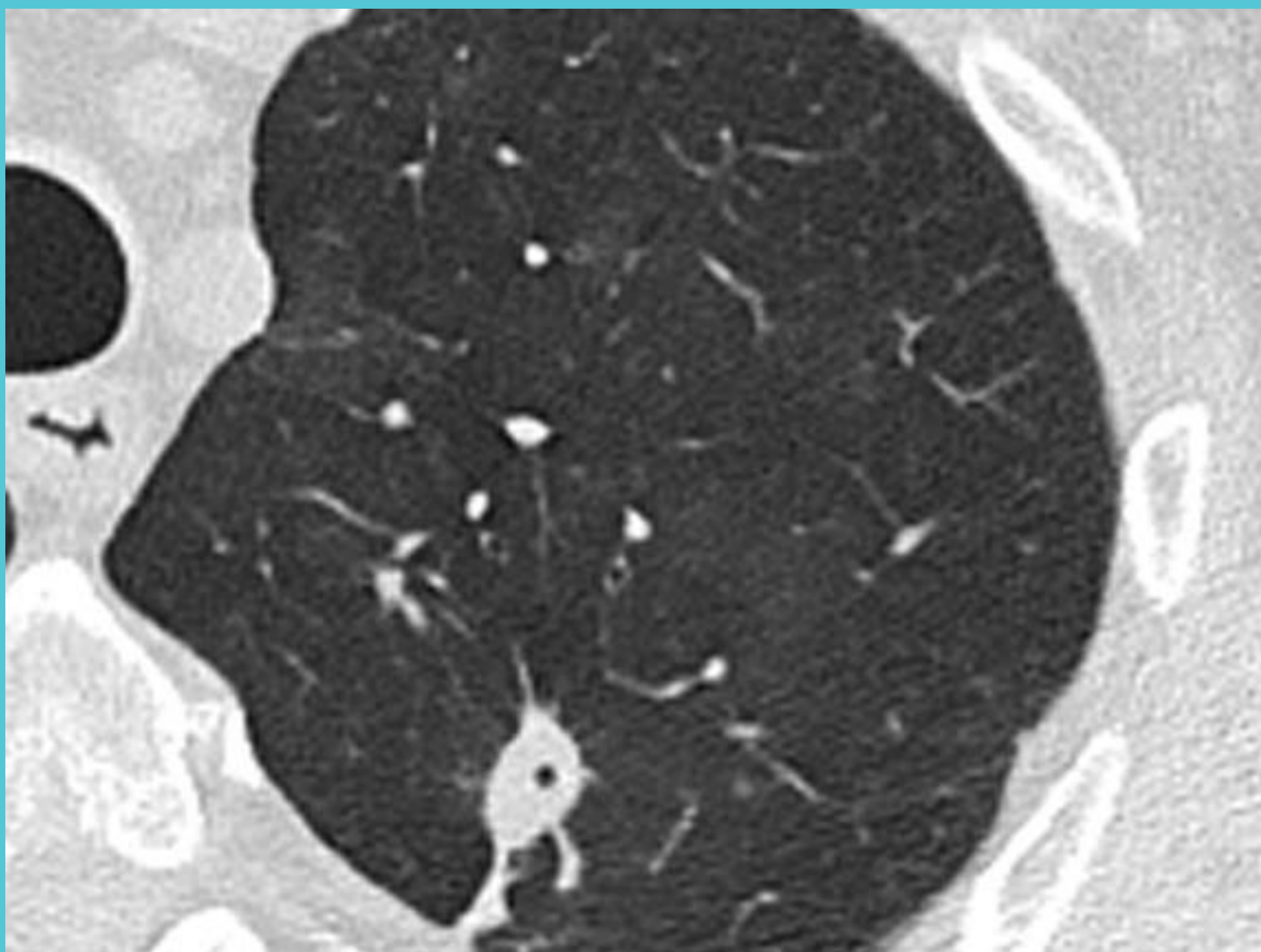
Where possible, the participant is recommended to return to the same imaging provider for future studies to facilitate image comparison.

Images!!



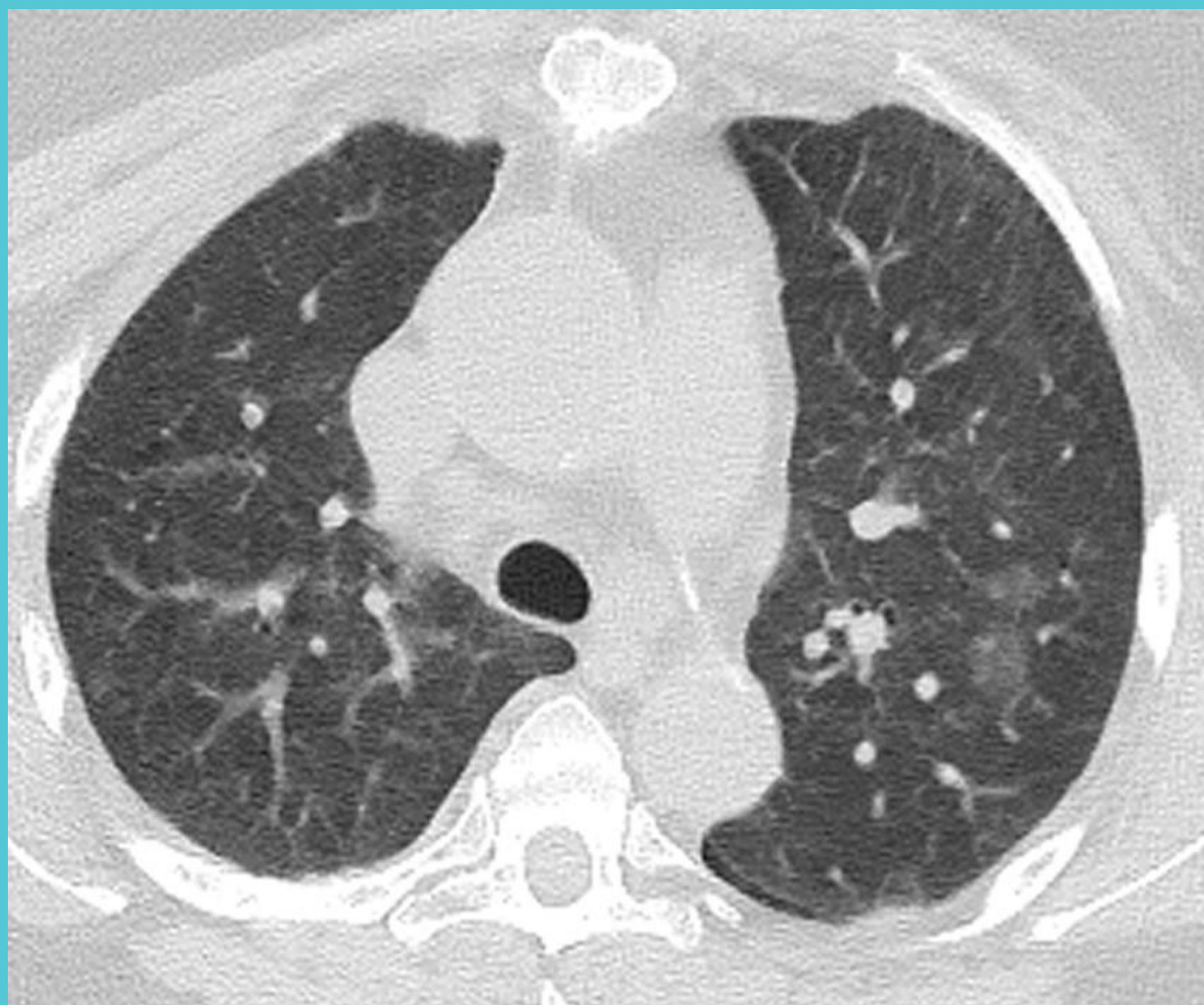


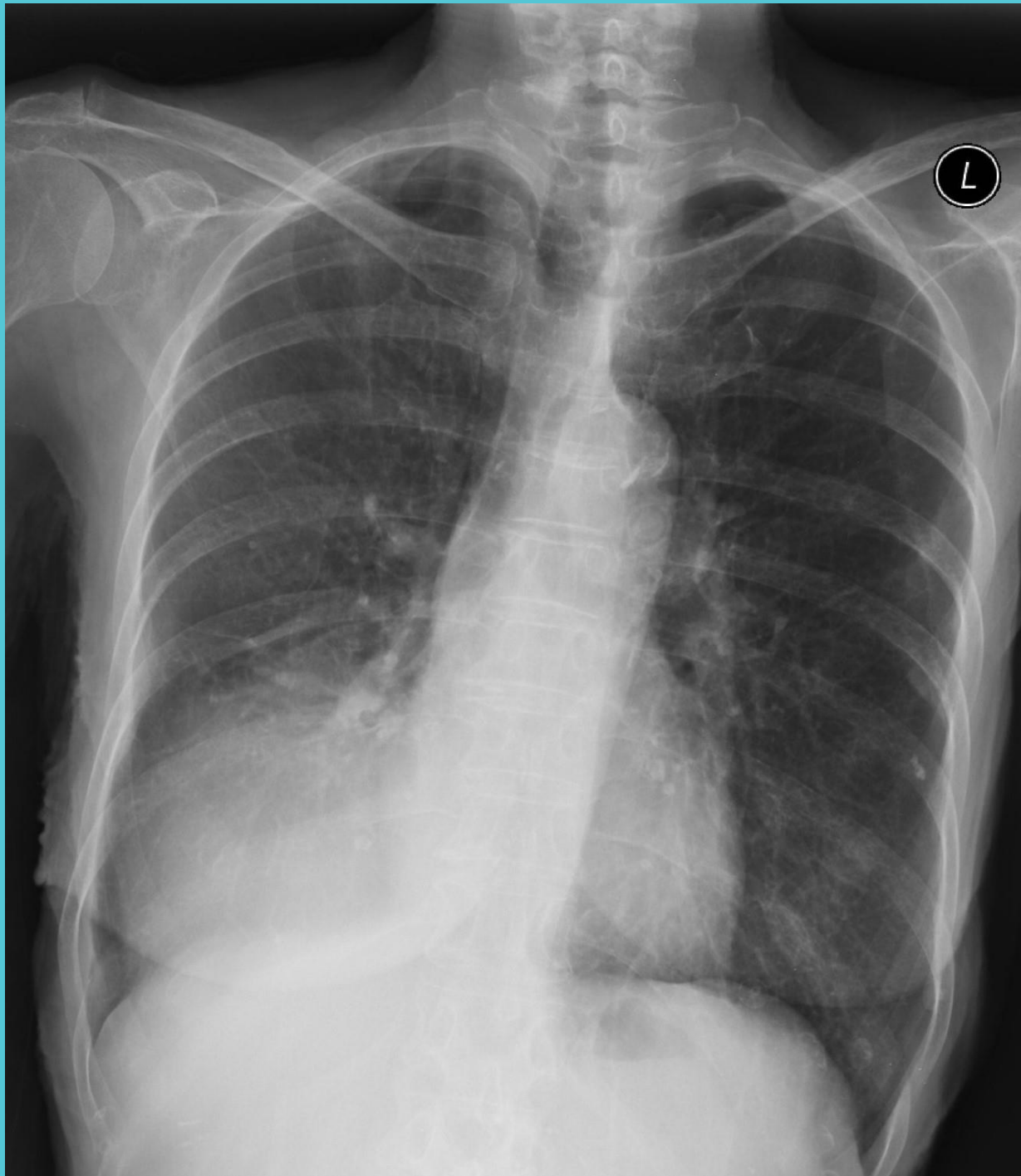


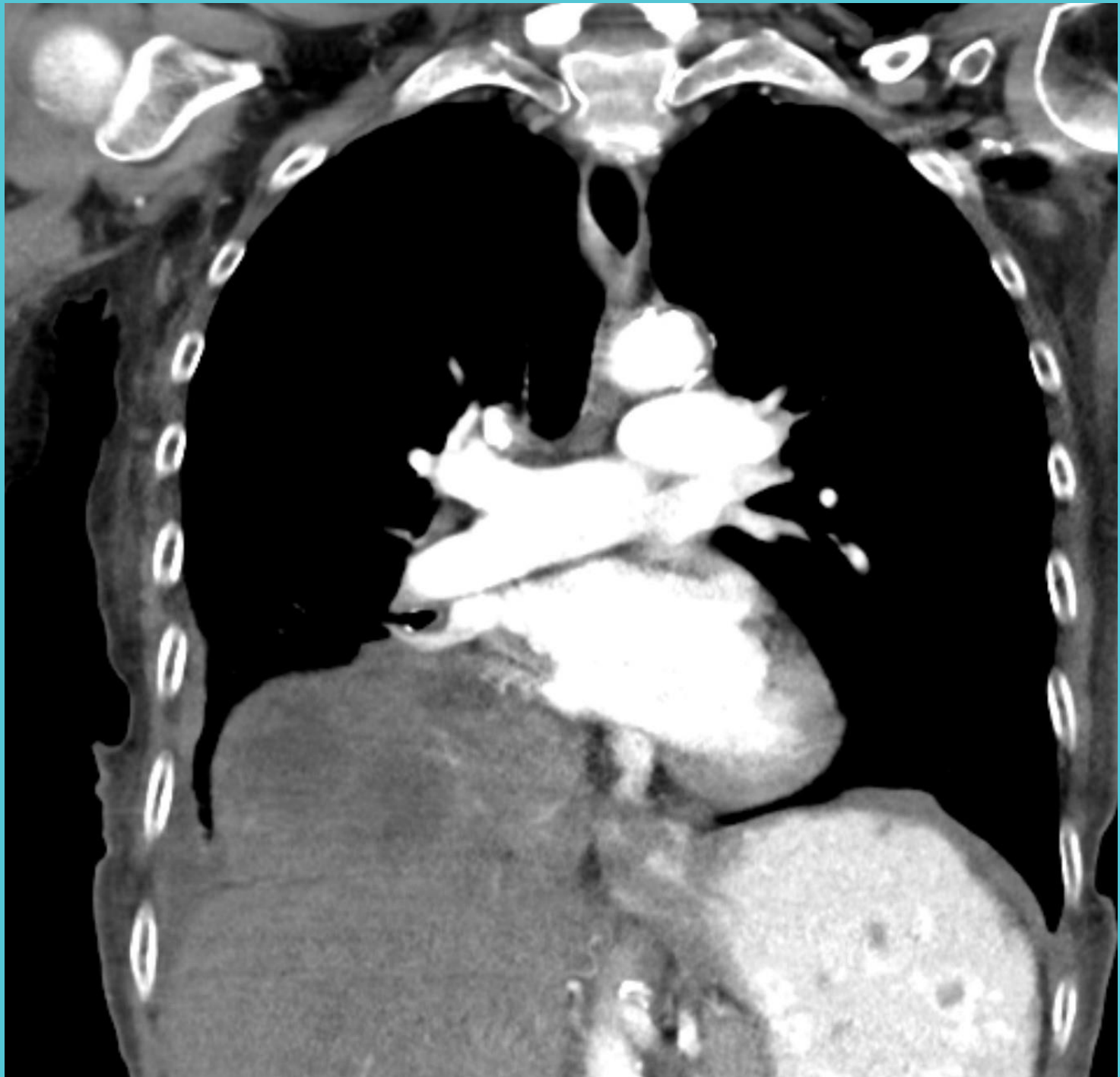






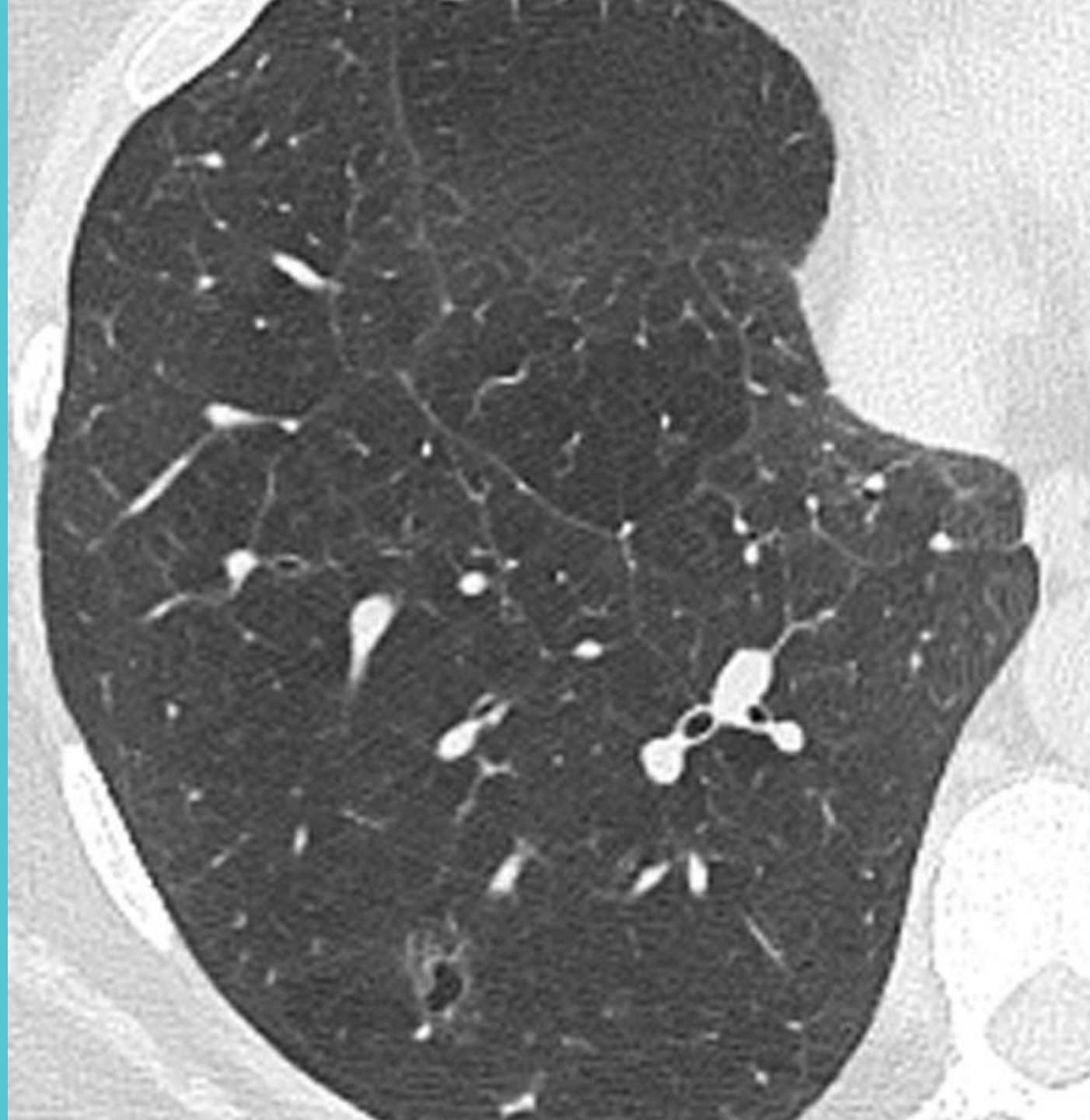










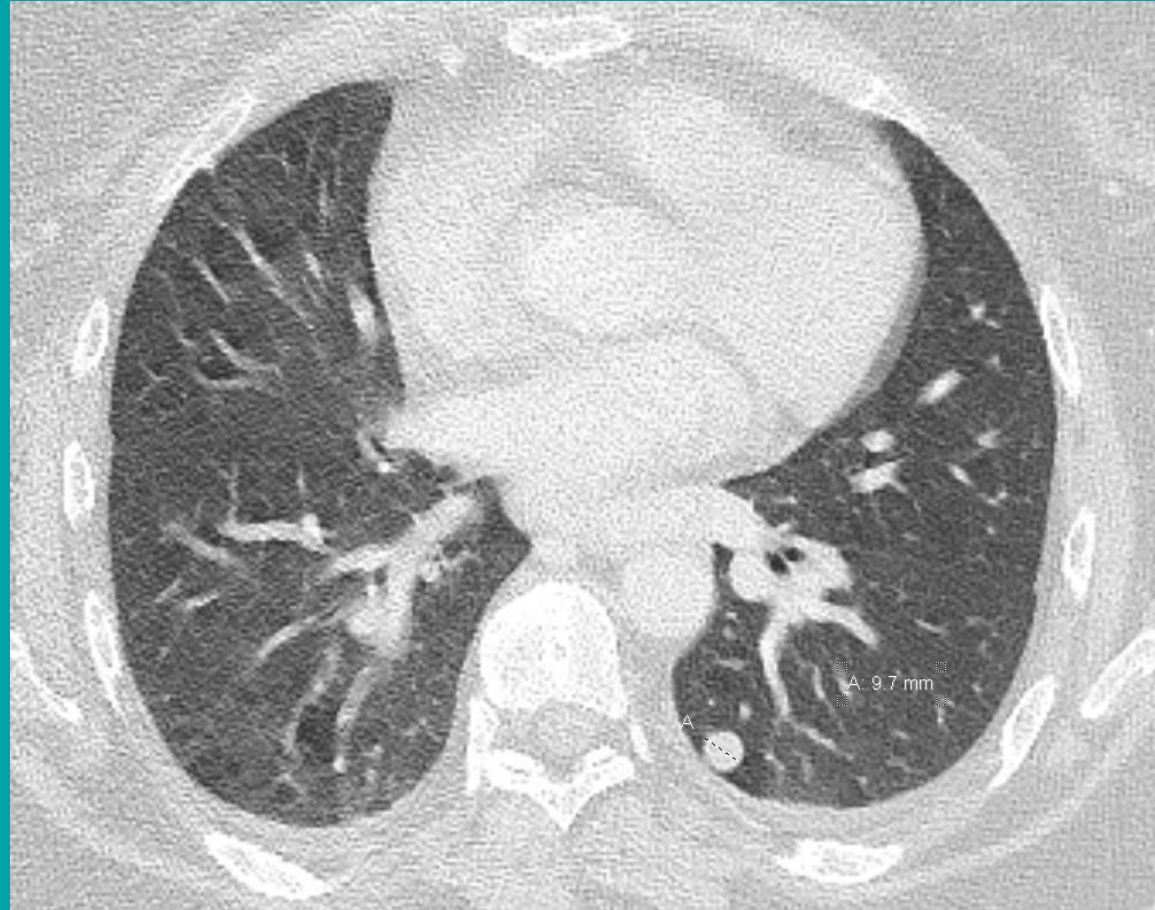




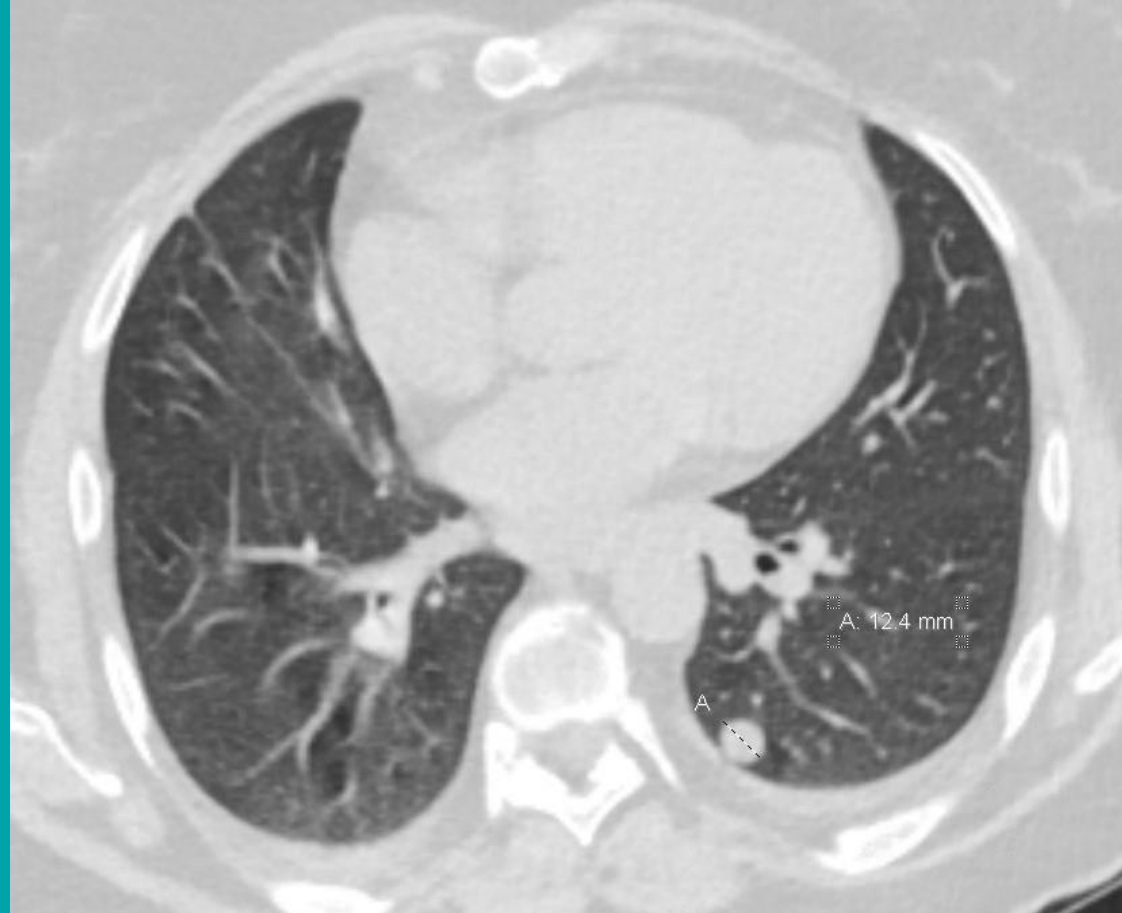




## Index Scan



2 years later ...



## Growth trajectory

### Volume-Doubling Time

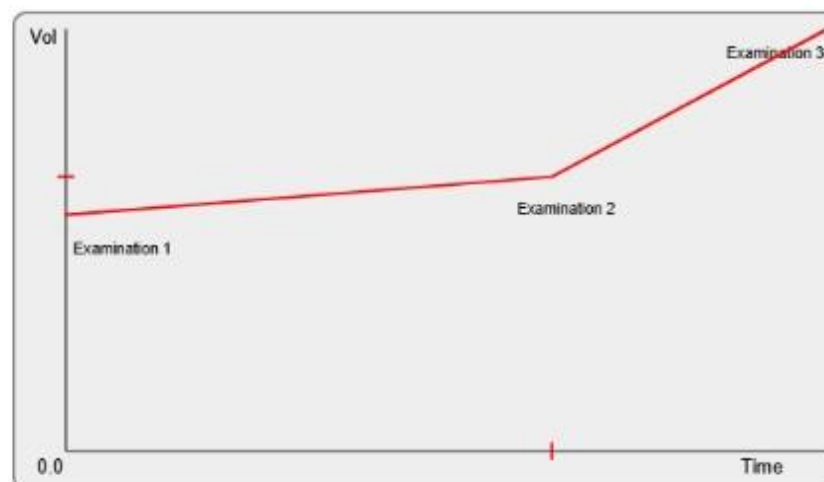
Online calculator for lung nodule volume-doubling time (VDT)

	Date	Dimensions	Volume (prism)	Volume (ellipsoid)
Examination 1	2023-08-09	<input type="text"/>	<input type="text" value="0.578"/>	
Examination 2	2024-08-23	<input type="text"/>	<input type="text" value="0.671"/>	
Examination 3	2025-03-27	<input type="text"/>	<input type="text" value="1.033"/>	

2day 3mo 6mo < Year > < Month > < Day >

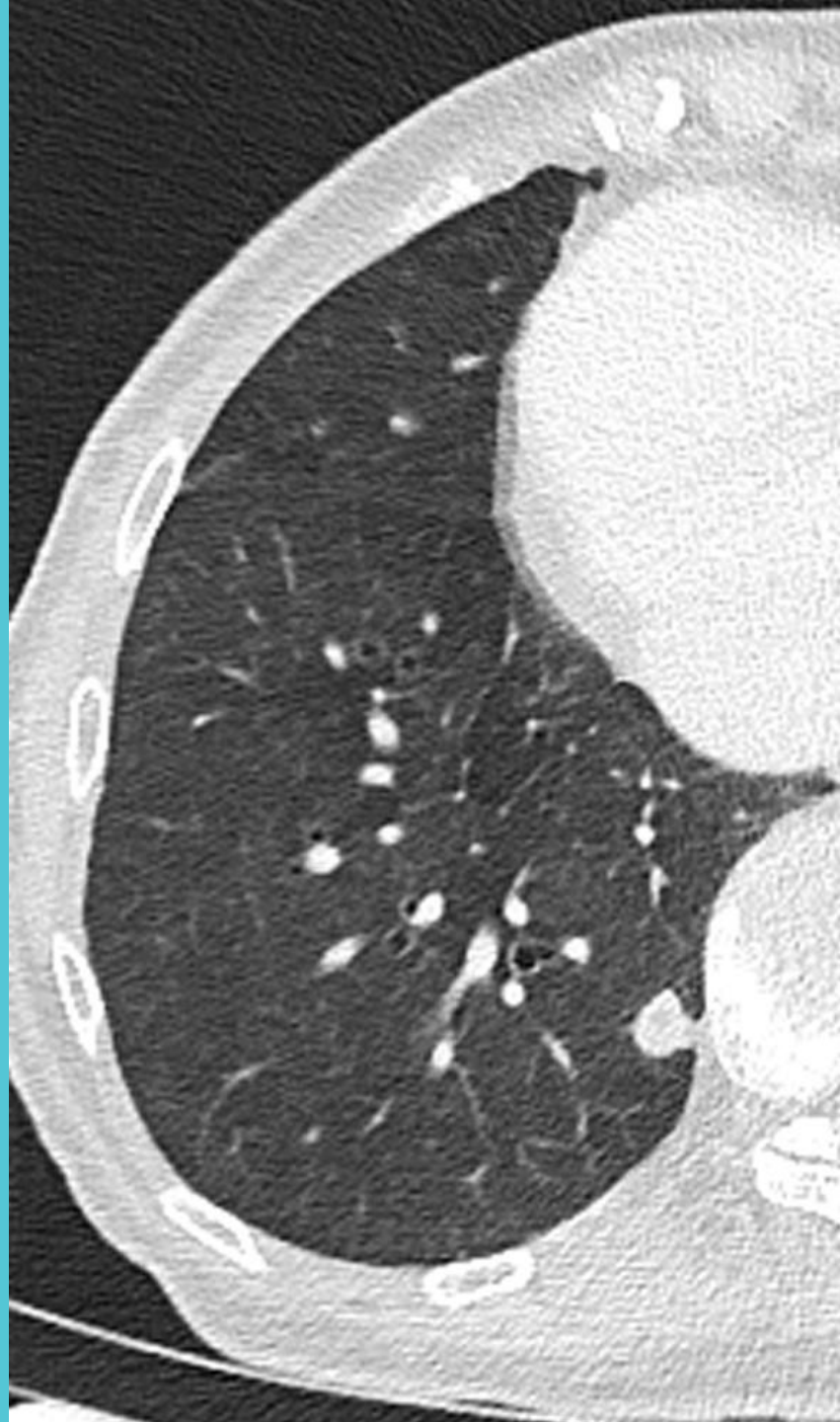
Date 3 Reset Help [About](#)

Interval	Days	VDT	Tumor cell doublings	Volume increase
Examination 1 - 2	380	1765.44	0.15	16%
Examination 2 - 3	216	347.01	0.43	54%
Examination 1 - 3	596	711.47	0.58	79%











chest scan



Radiology Tasmania

# What is Chest Scan?

## What is Chest Scan

---

Integral Diagnostics has launched a new brand, Chest Scan, aiming to become the provider of choice for referrers and patients participating in the National Lung Cancer Screening Program (NLCSP).

Chest Scan combines all of Integral Diagnostics' (IDX) expert radiologists, resources, brands and technology. Specialising in the early detection of lung cancers and diseases, Chest Scan, helps to ensure the best possible treatment options are available. With a team of highly trained radiologists across Australia, Chest Scan ensures expert interpretation and precise diagnosis. This collaboration enhances accuracy, efficiency, and patient care, ensuring timely and reliable results

Via the Chest Scan website [www.chestscan.com.au](http://www.chestscan.com.au) ;

- **Patients can gather general information about the NLCSP, including;**
  - Which IDX sites close to them are offering NLCSP scans
  - Understand their eligibility
  - Make digital enquiries about appointments (flowing directly to BookMi, for Radiology Tasmania)
- **Referrers can also access more detailed information about;**
  - Information on why they should choose Chest Scan and its partners for NLCSP patients
  - Patient Pathways following reporting



**Radiology Tasmania**





**Thank you for your attention**

Dr Robin Harle  
RHarle@idxgroup.com.au



Australian Government

NATIONAL  
**CANCER  
SCREENING**  
REGISTER

# Access and submission of patient screening data

**JOHN LEE**

Head of Engagement and Communication

June 2025

# SUPPORTING CONNECTED HEALTHCARE: THE NCSR SYSTEM



Australian Government

NATIONAL  
CANCER  
SCREENING  
REGISTER



## HEALTHCARE PROFESSIONALS



GP



Aboriginal  
Healthcare Worker



Specialist



Radiologist/  
Pathologist



### HEALTHCARE PROVIDER PORTAL

Accessed via Provider Digital Access (PRODA)

### INTEGRATED CLINICAL SYSTEMS

Clinical  
Information  
System (CIS)

Radiology  
Information  
System (RIS)

Laboratory  
Information  
System (LIS)



## PARTICIPANTS

## BUSINESS INTELLIGENCE (BI) & REPORTING PORTAL



Commonwealth & AIHW Authorised Users

## OTHER GOVERNMENT INTEGRATIONS

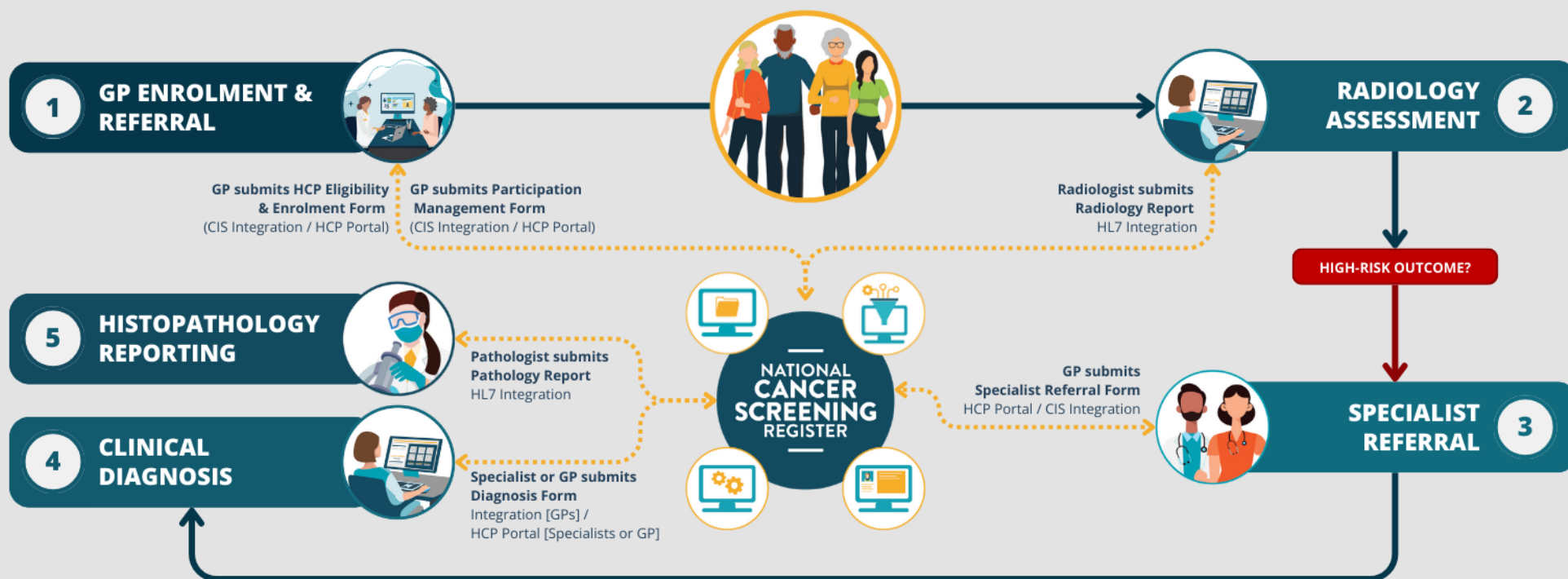


myGov  
PRODA  
Medicare  
PDS

Doc. Verification Service  
HI Service  
NASH PKI

# NCSR SOLUTION OVERVIEW

## HOW THE NCSR SUPPORTS LUNG SCREENING



# DIGITAL CHANNELS FOR HEALTHCARE PROVIDERS

- Healthcare Provider Portal
- **Clinical Software Integration** (Generic API, presently integrated with Best Practice Premier, MedicalDirector Clinical and Communicare)



Access your patient's bowel  
and cervical screening  
results and histories online  
View next screening action



Submit program forms  
electronically



Manage patient's details  
and preferences



Order Bowel Screening  
Test Kits



Accessed via PRODA or integrated clinical software



Australian Government



HCP Portal | Welcome to the De

NATIONAL CANCER SCREENING REGISTER

ParticipantMy ProfileMy CorrespondenceiFOBT Bulk Order

MILAGROSTU HLUCHCD(MILAGROSTU.HLUCHCD)Provider No: 0522483JLog Out

## Participant Search

All fields are required unless participant has one name only

Identifier Type  
Medicare

Medicare Number

Family Name

Given Name

Sex

Date Of Birth  
eg 06-Dec-1982

☐ Search records with only a Family Name

SearchReset

### Updated Participant Details and Alternative Access to Kits Model forms

Changes have been made to simplify these forms.

When issuing a kit to a patient through the [Alternative Access to Kits Model](#), you will now see a shorter form with a new name.

The previous form called **NBCSP - Alternative Access Model (Issue/Re-Issue Kit)** is now called **NBCSP - Bowel Kit Issued by Healthcare Provider**.

Records shown are those that have been processed and included in the National Cancer Screening Register at the date accessed. Information is sourced from various third parties, including healthcare professionals, pathology laboratories and State, Territory and Commonwealth government departments. If you have any queries about the accuracy or currency of any record, please contact the NCSR Contact





Australian Government

NATIONAL  
CANCER  
SCREENING  
REGISTER

# PRIMARY CARE ONBOARDING KIT

A guide to onboard healthcare organisations using compatible clinical software and help providers and staff make the most of the NCSR integration to support their patients in bowel and cervical screening.



View onboard toolkit

## WHY INTEGRATE WITH THE NATIONAL CANCER SCREENING REGISTER?

**Research shows** patients are more likely to participate in bowel and cervical screening after discussing it with a trusted health professional. Improved access to patient screening information is vital for facilitating meaningful conversations to highlight the life-saving potential of early detection and address any concerns about the screening process. The integration allows healthcare providers to access and submit comprehensive screening information for the bowel and cervical screening programs, directly from the practice management software they use daily. Integrating with the NCSR supports personalised healthcare, empowering providers to proactively manage and promote participation in Australia's bowel and cervical screening programs. By integrating your clinical software with the NCSR, you're not just improving practice efficiency – you're contributing to a nationwide effort to reduce deaths from bowel and cervical cancer.

Find out more about the benefits of integrating your clinical software with the NCSR

Visit [NCSR.gov.au/integrations](https://nscr.gov.au/integrations)

### INTEGRATION PARTNERS:

**Best Practice Premier** **Healthline**

**MedicalDirector Clinical** **Healthline**

**Communicare** **Healthline**

### CASE STUDIES:

**Enhancing Preventative Care:** Many of the practice management software registered to the NCSR are designed to take time and effort from your practice to ensure comprehensive patient care.

**3,500** **22%**

**91%** **94%**

### FUNCTIONS AND BENEFITS:

- ACCESS PATIENT SCREENING INFORMATION AND ALERTS: Stay informed with real-time updates on patient screening status, including overdue and follow-up alerts.
- VIEW AND SUBMIT SCREENING RESULTS: Including colonoscopy or colonoscopy findings, ensuring accurate program participation.
- FACILITATE BOWEL SCREENING TEST KIT COMPLETION: Order test kits to be mailed directly to a patient's address or record when a kit has been issued during a consultation as part of the consultation across 133 models. Note: Bulk test orders are made via the Healthcare Provider Portal.
- UPDATE PATIENT CONTACT AND DEMOGRAPHIC DETAILS: To ensure accurate screening records and support improved reporting to inform program policy and quality.
- VIEW PROGRAM-RELATED CORRESPONDENCE: Stay updated with program communications to track your patient's screening journey.
- NOMINATE PROVIDERS AND PERSONAL REPRESENTATIVES: Assign a healthcare provider or personal representative to ensure comprehensive patient care.

Page 1 NCSR Primary Practice Onboarding Kit | September 2024

## ABOUT THE NATIONAL CERVICAL SCREENING PROGRAM

The National Cervical Screening Program aims to prevent cervical cancer with routine HPV testing. Cervical cancer is one of the most preventable cancers. Most cervical cancers occur in people who have never screened or haven't screened for a long time. Healthcare providers play an important part in the program – by sharing your knowledge, you'll increase understanding of, and participation in, the program.

### THE ROLE OF HEALTHCARE PROVIDERS IN ELIMINATING CERVICAL CANCER IN AUSTRALIA

Healthcare providers are crucial to reaching Australia's goal of eliminating cervical cancer by 2035. Promoting and encouraging HPV vaccinations and routine cervical screening ensure early detection, or in many cases prevent cervical cancer developing at all. Educating patients about screening options, including self-collection, is essential for boosting participation, especially among those hesitant about traditional tests. By raising awareness of self-collection as an accessible alternative, providers can empower more patients to screen. Leveraging NCSR integration, providers can easily track, remind, and follow-up with patients to support improved outcomes.

Find out more about the elimination strategy

Health.gov.au/NCSR

**AGE ELIGIBLE COHORT:** Women and people with a cervix aged 25-74 years are invited to have a Cervical Screening Test (CST) through their healthcare provider every 5 years.

**PARTICIPATION:** 4,708,848 participants aged 25-74 had a screening HPV test in 2019-2022 (88.4% of the target population)\*.

**CANCER CASES AND INCIDENCE RATE:** 818 new cases in the 25-74 age group were reported in 2019 (incidence rate of 13.1 cases per 100,000 people)\*.

\* Source: [Source: National Cervical Screening Program monitoring report 2024](https://nscr.gov.au/cervical-screening-program-monitoring-report-2024)

### RESOURCES:

**Clinical Guidelines**

For the management of screen-detected abnormalities, screening process, population and management of abnormal vaginal bleeding.

**Self-collection for the Cervical Screening Test**

Healthcare providers play a critical role in supporting patients with self-screening, including self-collection.

**Healthcare provider toolkit**

Resources and information to help healthcare providers engage patients and encourage participation in cervical screening.

**The role of health professionals**

Find out how you can help protect patient awareness of the importance of regular cervical screening.

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## ABOUT THE NATIONAL BOWEL CANCER SCREENING PROGRAM

The National Bowel Cancer Screening Program aims to reduce deaths from bowel cancer by detecting early signs of the disease. If found early, more than 90% of cases can be successfully treated. Eligible Australians aged 45 to 74 can do a free test at home every 2 years. Health professionals play an important role in encouraging eligible patients to take part in bowel cancer screening, demystifying the process, and managing positive test results.

### ALTERNATIVE ACCESS TO BOWEL SCREENING KITS FOR HEALTHCARE PROVIDERS

To increase bowel cancer screening rates, healthcare providers can now bulk order kits for their medical organisation to issue to eligible patients during an appointment. Many patients are more likely to complete the test after discussing it with a trusted healthcare provider. You play an important role in helping your patients make informed decisions about bowel cancer screening.

Find out more about the alternative access model

Health.gov.au/NBSCP

### AGE ELIGIBLE COHORT:

People aged 50-74 are sent a free screening test kit every 2 years.

People aged 45 to 49 can request their first free screening test kit be mailed to them and will be sent a kit every two years after they complete the test.

### RESOURCES:

**Clinical Guidelines**

For the prevention, early detection and management of colorectal cancer.

**Doing a bowel screening test**

Information for patients, eligibility, how to do the home test and understanding results.

**The role of health professionals**

Learn how to encourage your patients to take part in bowel cancer screening.

**Managing patients not suitable for the program**

Understand the options for people with bowel conditions who have had bowel surgery.

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## BEST PRACTICE PREMIER ENABLING THE NCSR INTEGRATION

### STEP 1: REGISTER YOUR PRACTICE

Before integrating Best Practice Premier with the NCSR, your medical practice must first be registered to PRODA and the NCSR Healthcare Provider Portal. This process takes around 15 minutes.

#### IMPORTANT INFORMATION TO HAVE READY:

- A registered individual PRODA account linked to your healthcare organisation, and you must be assigned the role of either:
  - Responsible Officer: Typically has login access to your organisation's Australian Business Register account.
  - Approved Delegate: Someone designated by the Responsible Officer to manage functions in PRODA on behalf of the organisation who must have the NCSR CS Terms and Conditions Attribution Delegation assigned to their PRODA account.
- The Responsible Officer or Approved Delegate must be listed as an Associate or Authorized Contact in the Australian Business Register, with a matching PRODA account name.
- An active Australian Business Number (ABN).
- Your Healthcare Provider Identifier Organisation (HP-IO) number.
- Ensure it matches the HP-IO number recorded against your clinical software vendor.

### REGISTRATION GUIDES:

**Registration Walkthrough Video**

**Registration Quick Start Guide**

**NCSR Registration Detailed Guide**

**REGISTRATION TECHNICAL SUPPORT:**

**Book a callback from the NCSR**

**Call the NCSR on 1800 627 701**

### STEP 2: INSTALL THE FHIR API

Before setting up the NCSR integration, it's crucial that you install the FHIR API on your practice server. If this step is not completed, an error will occur when attempting to access and submit NCSR forms.

Guide for setting up FHIR connection

### STEP 3: ENABLE THE NCSR INTEGRATION

You will need to enable the integration at both a practice level and for the individual providers who use it. You can then download the NCSR Hub.

Enable the integration in Best Practice Premier

**BEST PRACTICE TECHNICAL SUPPORT:**

**Contact BP support**

**Visit BP Premier Software NCSR**

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## COMMUNICARE ENABLING THE NCSR INTEGRATION

### STEP 1: REGISTER YOUR MEDICAL ORGANISATION

Before integrating Communicare with the NCSR, your medical organisation must first be registered to PRODA and the NCSR Healthcare Provider Portal. This process takes around 15 minutes.

#### IMPORTANT INFORMATION TO HAVE READY:

- A registered individual linked to your healthcare organisation, and your PRODA account must be assigned the role of either:
  - Responsible Officer: Typically has login access to your organisation's Australian Business Register account.
  - Approved Delegate: Someone designated by the Responsible Officer to manage functions in PRODA on behalf of the organisation who must have the NCSR CS Terms and Conditions Attribution Delegation assigned to their PRODA account.
- The Responsible Officer or Approved Delegate must be listed as an Associate or Authorized Contact in the Australian Business Register, with a matching PRODA account name.
- An active Australian Business Number (ABN).
- Your Healthcare Provider Identifier Organisation (HP-IO) number.
- Ensure it matches the HP-IO number used for your medical practice's Medicare account.

### REGISTRATION GUIDES:

**Registration Walkthrough Video**

**Registration Quick Start Guide**

**NCSR Registration Detailed Guide**

**REGISTRATION TECHNICAL SUPPORT:**

**Book a callback from the NCSR**

**Call the NCSR on 1800 627 701**

### STEP 2: Enable the integration within Communicare

Follow the instructions provided by Communicare to enable the integration. You'll need to have your organisation's NABID certificate ready.

You'll also have the option to enable access for nurses and practice staff as delegates of a healthcare provider with a Medicare provider number and set system rights. When Communicare is next started, for users who belong to a group that has the NCSR system rights enabled, alerts will display in the banner of a patient's clinical record if that patient is matched to the NCSR database.

Users can also link to the NCSR Hub from the patient record.

Enable the integration in Communicare

**COMMUNICARE TECHNICAL SUPPORT:**

**Contact Communicare support**

**Communicare Knowledge Centre**

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## MEDICALDIRECTOR CLINICAL GETTING THE MOST OUT OF THE NCSR HUB

### SUPPORTING YOUR PATIENTS

The NCSR Hub aims to provide you with greater visibility of your patient's screening status to help prompt important discussions about cancer screening. It allows providers and practice staff to access screening information, including your patient's screening history and results, overdue and follow-up alerts, and submit demographic and clinical updates to the NCSR.

You can also facilitate bowel screening test completion by recording when you have issued a program test kit to a patient during a consultation or when a patient is ordered a kit to be mailed to your patient's address.

**ADVERSE EVENTS REPORT:** For colorectal cancer to report on a patient's adverse events.

**COLORADO COPY REPORT:** Report results for a patient with a positive FOBT result.

**HISTOPATHOLOGY REPORT:** Report results of specimens collected during colonoscopy.

**Enhancing Preventative Care:**

Need about Best Practice Premier experience with the integration and how to help your patients to take time and effort from your practice to ensure comprehensive patient care.

### SUBMITTING INFORMATION TO THE NCSR

Information about a patient's demographics and screening history held within the NCSR is used to apply the correct screening pathway. To help the NCSR provide a safety net for the programs, healthcare providers can update their patient's details and submit information on the NCSR Hub.

The NCSR Hub aims to make it easier to update your patient's record to make sure they receive appropriate care and avoid unnecessary follow-ups for high-risk results.

**BOWEL FORMS:**

**GP ASSESSMENT REPORT:** Provide information about a patient with a positive FOBT result.

**ADVERSE EVENTS REPORT:** For colorectal cancer to report on a patient's adverse events.

**COLORADO COPY REPORT:** Report results for a patient with a positive FOBT result.

**HISTOPATHOLOGY REPORT:** Report results of specimens collected during colonoscopy.

**ADDITIONAL INFORMATION:** Applies total hysterectomy flag against a patient's record.

### USER GUIDES

The following guides have been developed to support you using the NCSR Hub, including viewing previous screening results, submitting clinical forms and ordering bowel screening test kits.

**On-demand webinar**

Watch this webinar to learn what the NCSR is and how to use it, and access the NCSR Hub with Standard access.

**Webinar: Local Cancer Screening Register**

Webinar for local cancer screening register.

**Detailed guide for the NCSR Hub**

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# Update- New personalised accounts

## Registering for the first time

Registering for and accessing HealthPathways for the first time - Individual HealthPathways accounts.



Scan to learn more

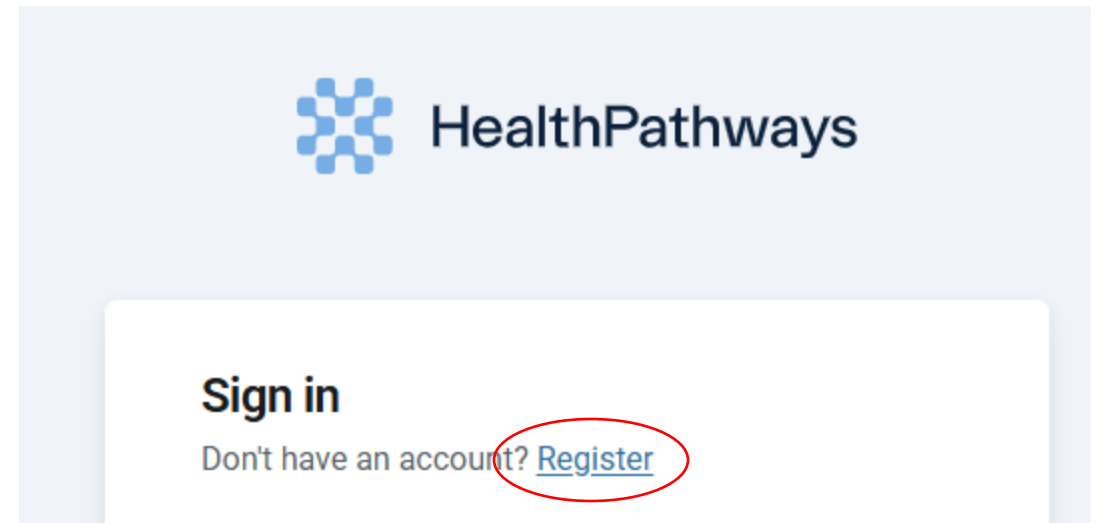


Have a question? Contact the Tasmanian HealthPathways team [HealthPathways@primaryhealthtas.com.au](mailto:HealthPathways@primaryhealthtas.com.au)

# Sign up for a personalised account today!



Scan to register  
now



**The generic login will cease on Tuesday 1<sup>st</sup> July**

# Some final words

- After this webinar end, your browser will open a link to an evaluation survey.
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