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?

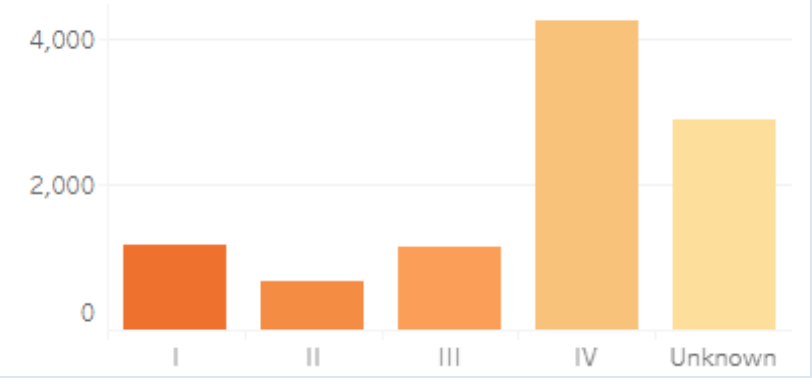
- First new cancer screening program in nearly 20 years
- Leading cause of cancer related deaths in Australia – esp ATSI
- Just under half of lung cancers are diagnosed at stage 4 and significantly different 5 year survival rates between stages
- Aiming to detect lung cancer early to improve mortality and enhance changes are 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

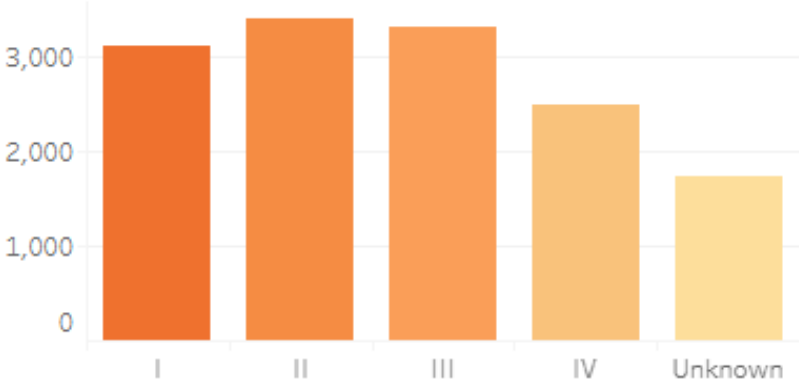


Incidence

Colorectal cancer (C18–C20), 2011

Number of cases, by stage at diagnosis

Colorectal cancer, Persons

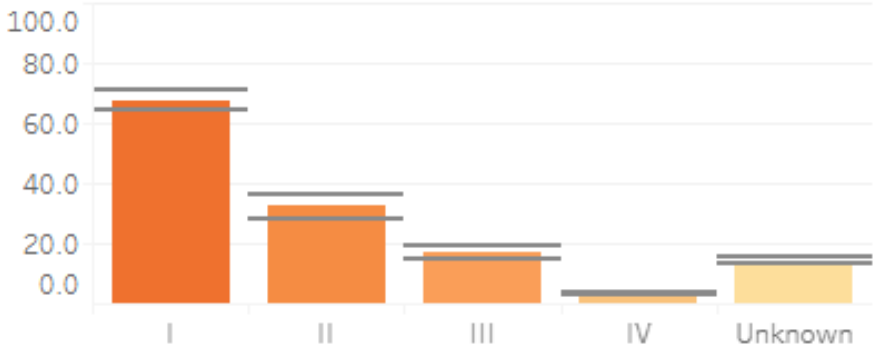


Survival

Lung cancer (C33–C34), 2011–2016

5-year relative-survival, by stage at diagnosis

Lung cancer, Persons

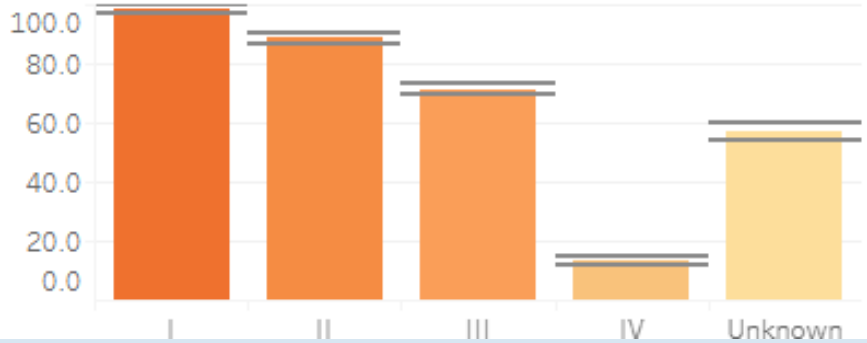


Survival

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.

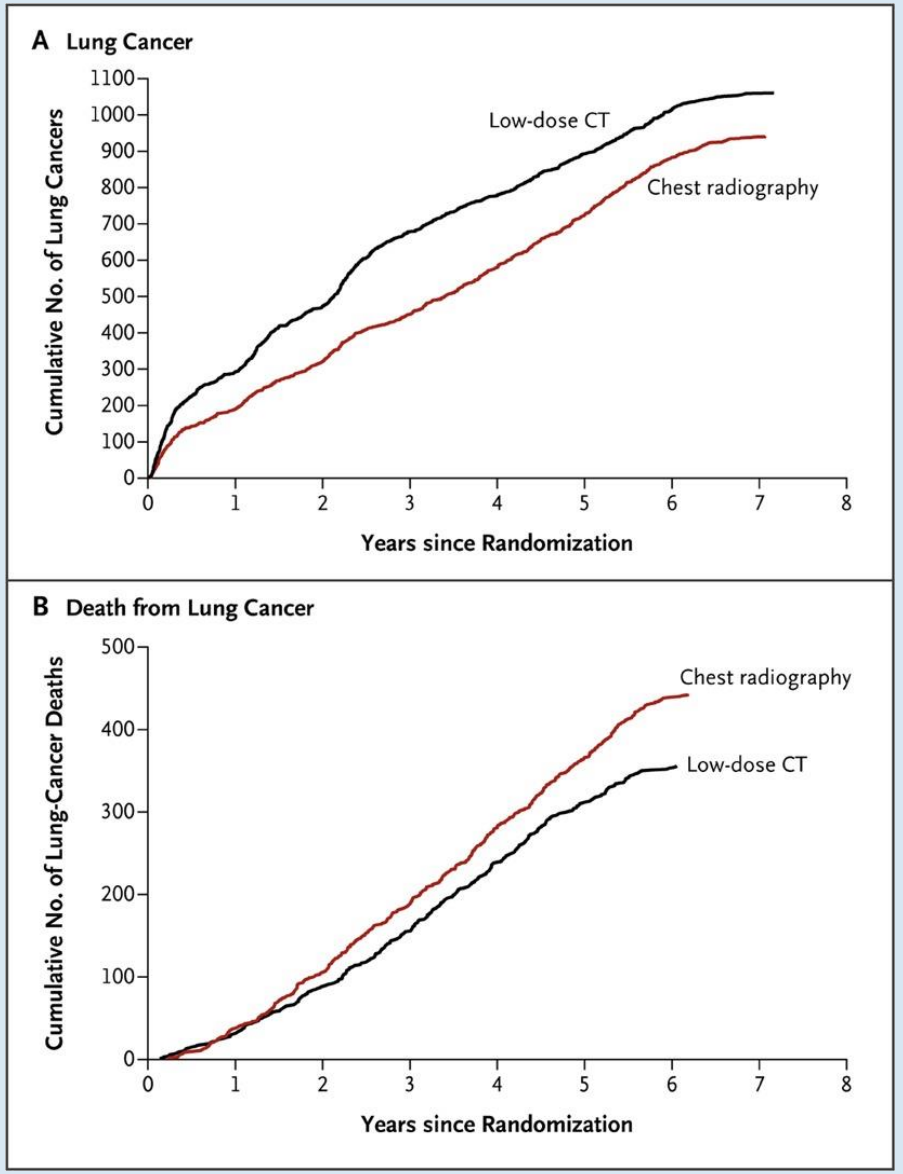
METHODS

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.

*A complete list of members of the National Lung Screening Trial research team is provided in the Supplementary Appendix, available at NEJM.org.

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



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 Hoesein, 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.

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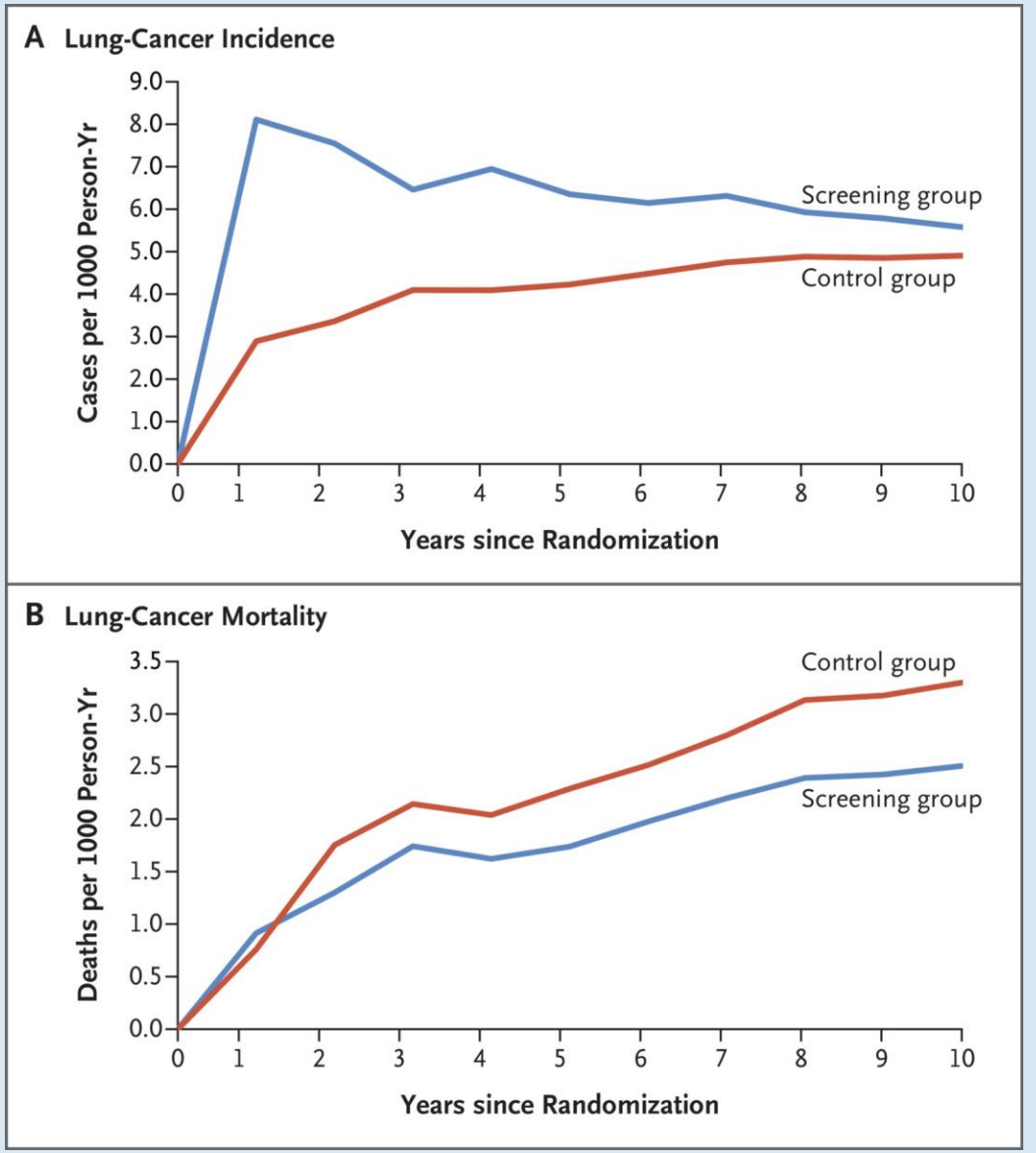
DOI: 10.1056/NEJMoa1911793



Eligibility

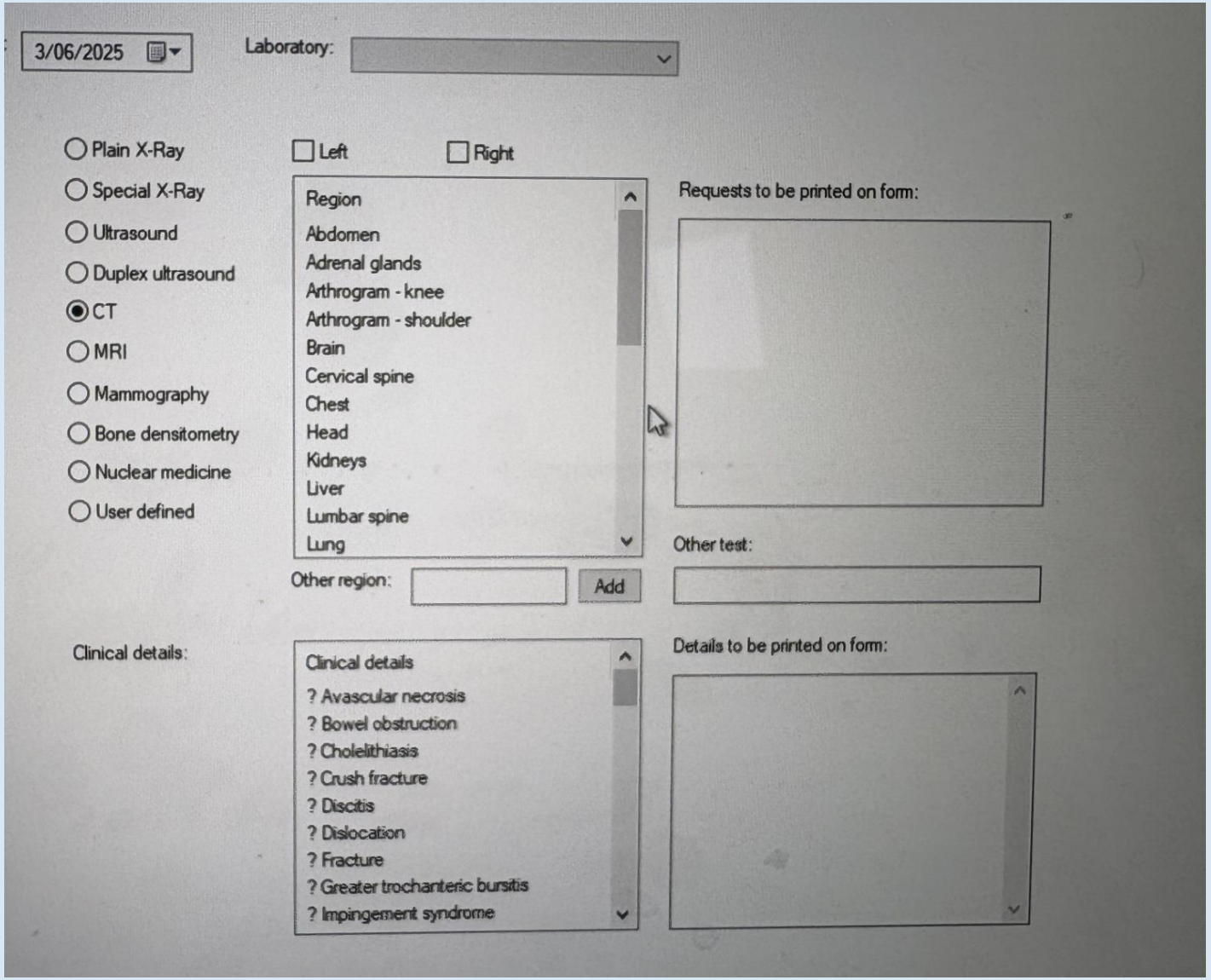
Suitability

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.



NATIONAL LUNG CANCER SCREENING PROGRAM IMAGING REQUEST

Australian Government | 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 Straight 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: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

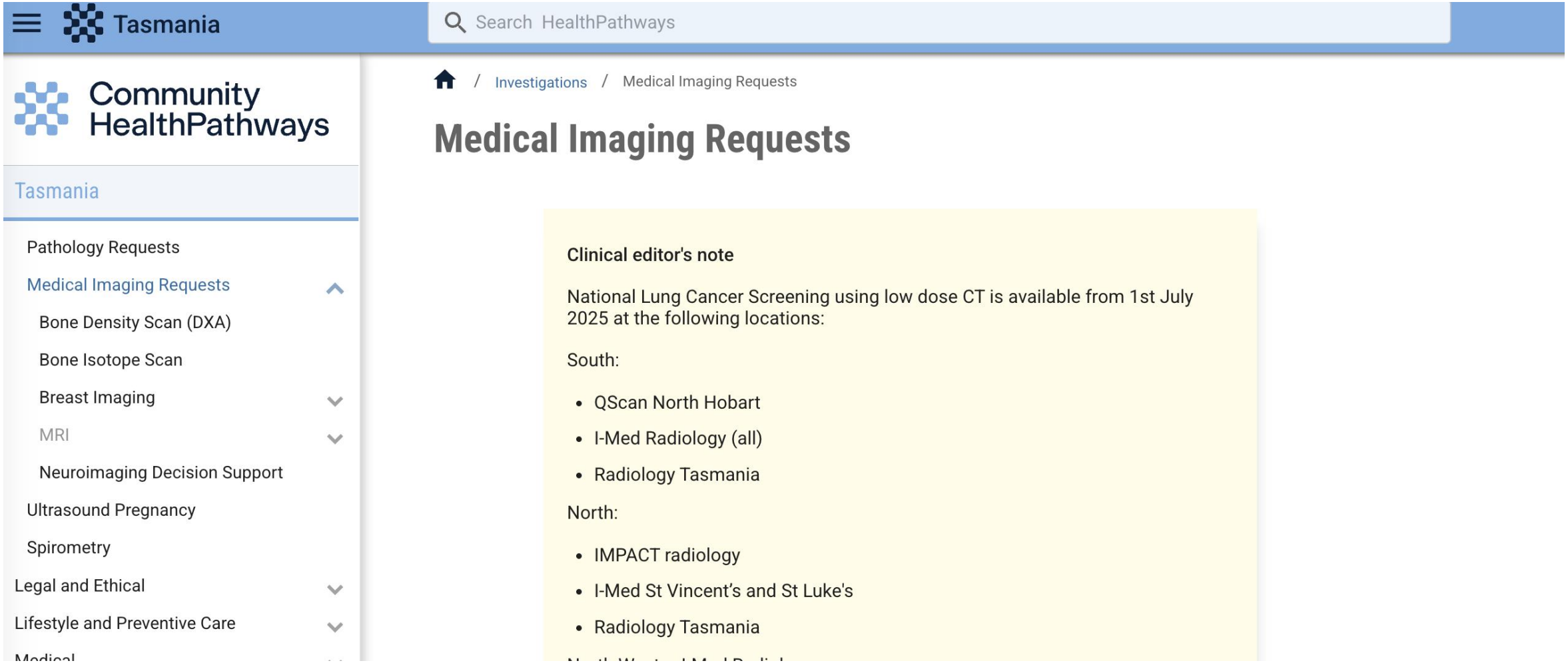
Address:

Phone: ☐☐☐☐☐☐☐☐☐☐ **Fax:** ☐☐☐☐☐☐☐☐☐☐

Signature: **Date:** ☐☐/☐☐/☐☐☐☐

Send copy to:

Where to send?




XF
DAF
DAF
HEART 5


PHILIPS
HEART of AUSTRALIA
HEART of AUSTRALIA
Incisive CT
PHILIPS

Quit 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

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

2 Eligibility assessment appointment

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.

3 The low-dose CT scan

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

4 Refer or recall for investigation

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

5 Requesting practitioner follow-up and rescreening

A For each scan, participants will need to book an appointment with you for a new low-dose CT scan request.*

B Those with no significant findings will be reminded about screening every two years if they have opted in for communication from the NCSR.****

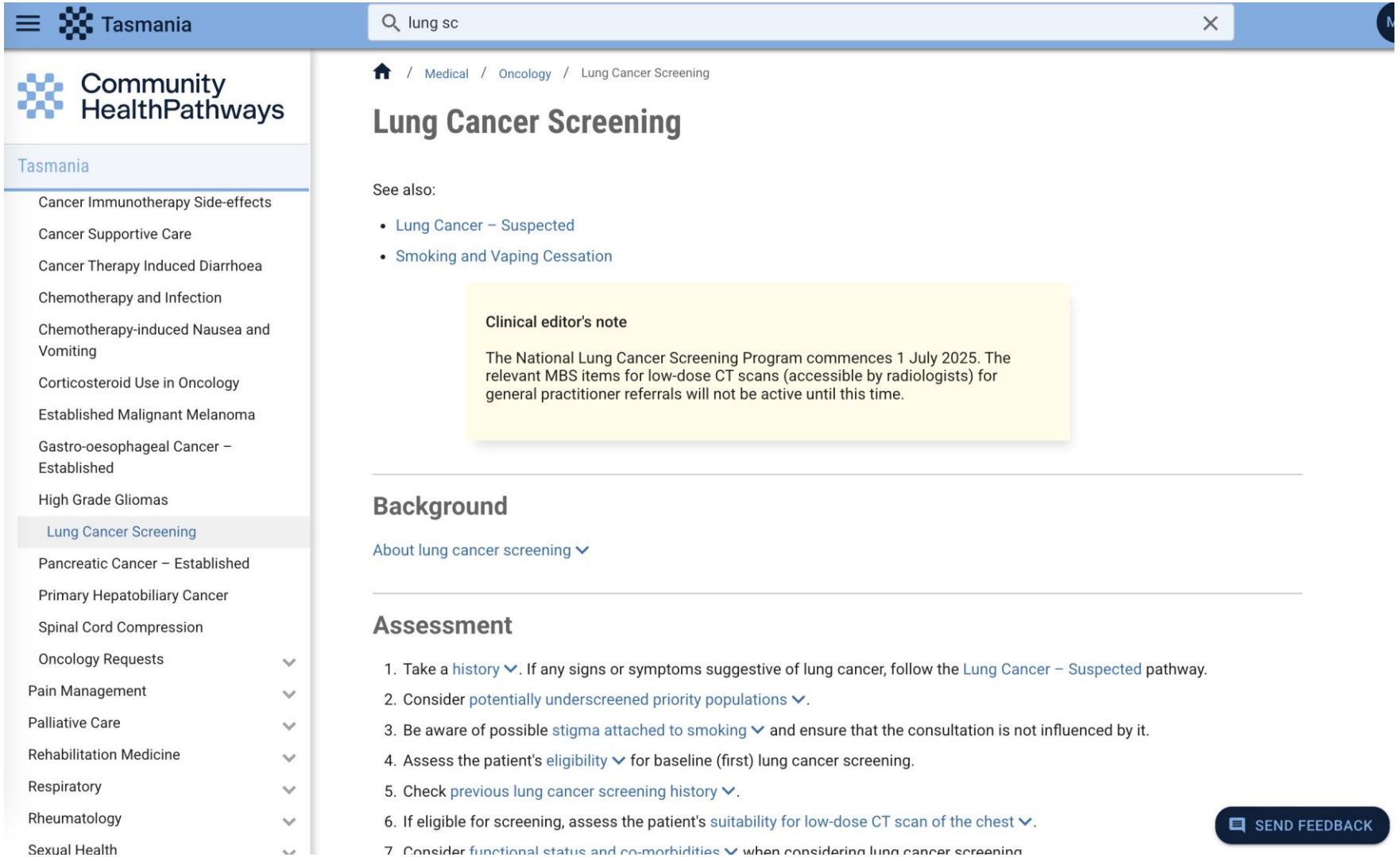
C For participants who have opted out of the NCSR, you will need to remind them and follow up about all screening.

D Those with findings will be reminded about interval scans at 3, 6 or 12 months. Those without findings will be reminded every two years.

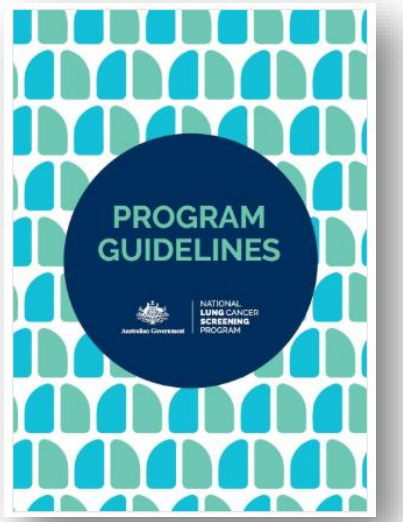
Additional notes

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

Resources

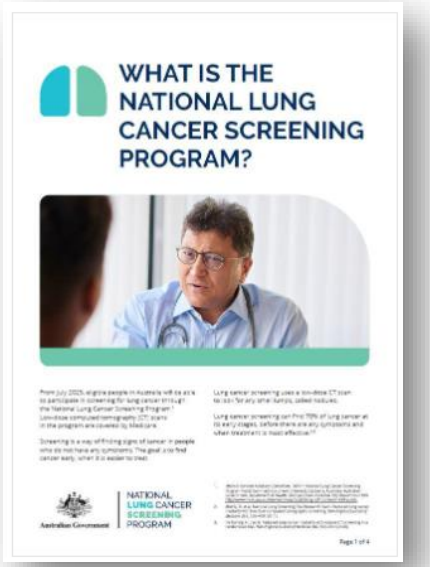

Tasmania
lung sc
Community HealthPathways
Tasmania
Cancer Immunotherapy Side-effects
Cancer Supportive Care
Cancer Therapy Induced Diarrhoea
Chemotherapy and Infection
Chemotherapy-induced Nausea and Vomiting
Corticosteroid Use in Oncology
Established Malignant Melanoma
Gastro-oesophageal Cancer – Established
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
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
1. Take a history. If any signs or symptoms suggestive of lung cancer, follow the Lung Cancer – Suspected pathway.
2. Consider potentially underscreened priority populations.
3. Be aware of possible stigma attached to smoking and ensure that the consultation is not influenced by it.
4. Assess the patient's eligibility for baseline (first) lung cancer screening.
5. Check previous lung cancer screening history.
6. If eligible for screening, assess the patient's suitability for low-dose CT scan of the chest.
7. Consider functional status and co-morbidities when considering lung cancer screening
SEND FEEDBACK

National Lung Cancer Screening Program – resources for the health sector

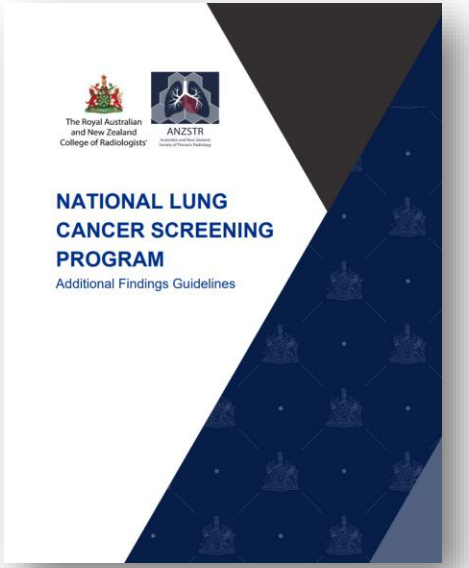


Program guidelines
Healthcare providers

eLearning modules
Healthcare providers



Information materials
Consumers &
healthcare providers



Guidance, education & training
Radiology sector

More information: health.gov.au/nlcsp

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

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Radiology Tasmania

Why do we think 2 years safe?

- We have learnt from the other screening programs!
- 1st 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

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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

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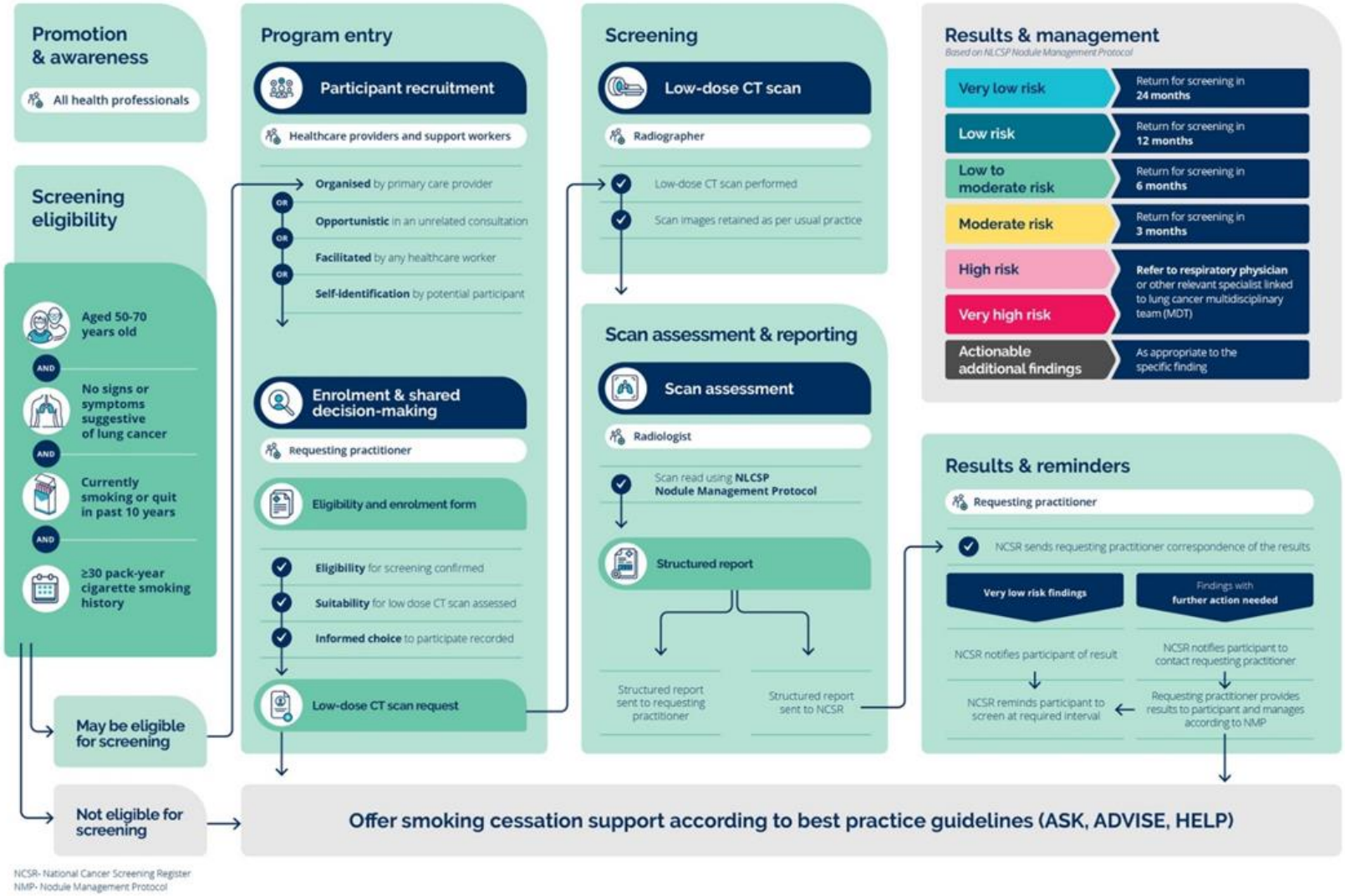
Screening and Assessment Pathway



NCSR- National Cancer Screening Register
NMP- Nodule Management Protocol

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The Patient Journey – A High Level Overview

GP ASSESSMENT

Assess the eligbility of your patients for the National Lung Cancer Screening Program. If eligible refer your patient for a low-dose chest CT through one of our radiology partners.

IMAGING

Patients book a low-dose chest CT scan directly through one of our imaging partners. Their scan will be bulk billed.

RESULTS SENT

Our radiology partners will send you a structured radiology report (Standardised Volumetric Doubling Time (VDT) monitoring is used). Initial and subsequent scans will be reported using PanCan Nodule Management Protocol.

FOLLOW UP SCANS

The National Cancer Screening Register will not hold scan images, but will provide patients with reminders. Consistent use of the same radiology provider is good practice to ensure accurate and comparable data over time.

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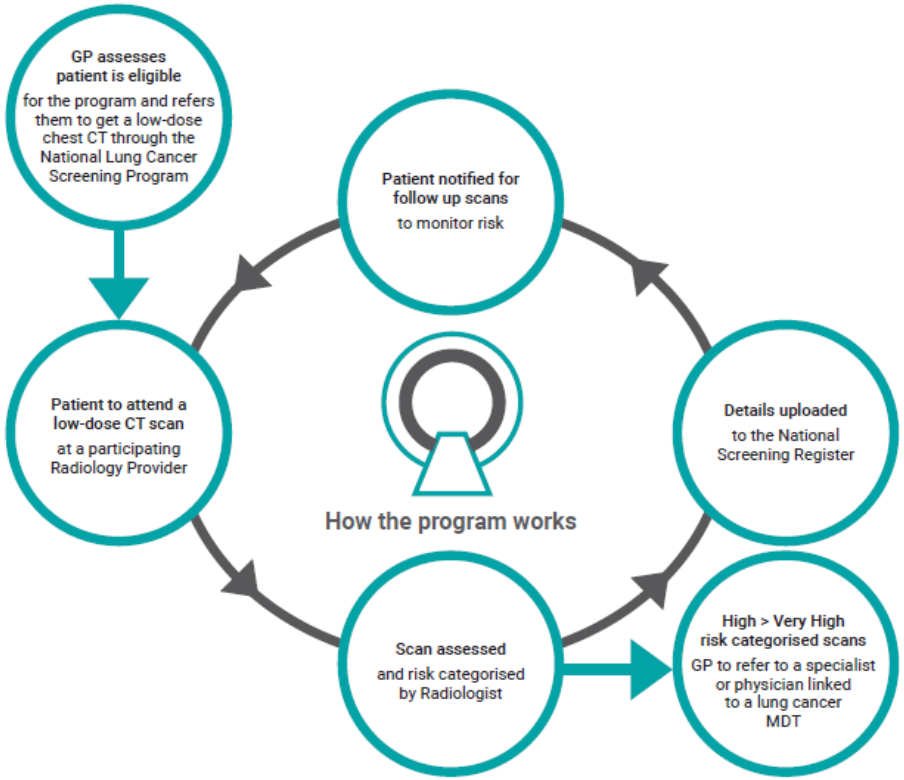
The Patient Journey



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Medicare Items & Booking Codes

New Items

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.)

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Medicare Items & Booking Codes

New Items – Plain Language Explanation

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 1st degree relative, details of any previous chest CT (if known) and history of any cancer

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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

chest scan

NATIONAL LUNG CANCER SCREENING PROGRAM

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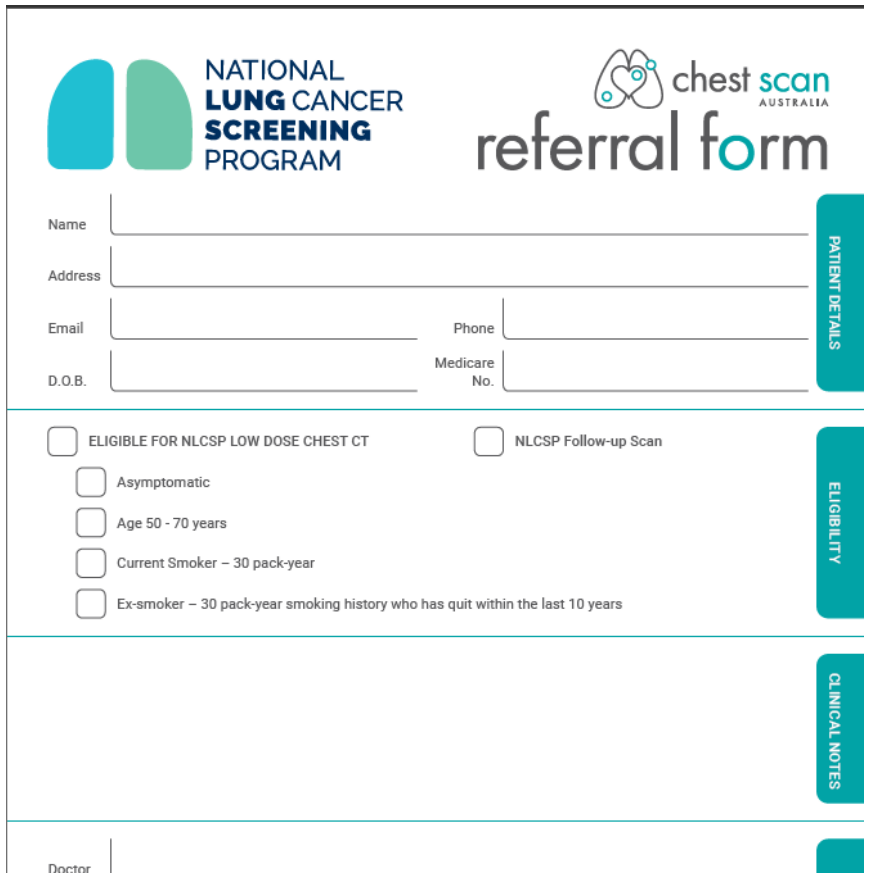
Imaging Requests – NLCSP & Chest Scan Examples



NATIONAL LUNG CANCER SCREENING PROGRAM

chest scan AUSTRALIA

referral form

Name

Address

Email

Phone

D.O.B.

Medicare No.

PATIENT DETAILS

ELIGIBLE FOR NLCSP LOW DOSE CHEST CT

NLCSP Follow-up Scan

Asymptomatic

Age 50 - 70 years

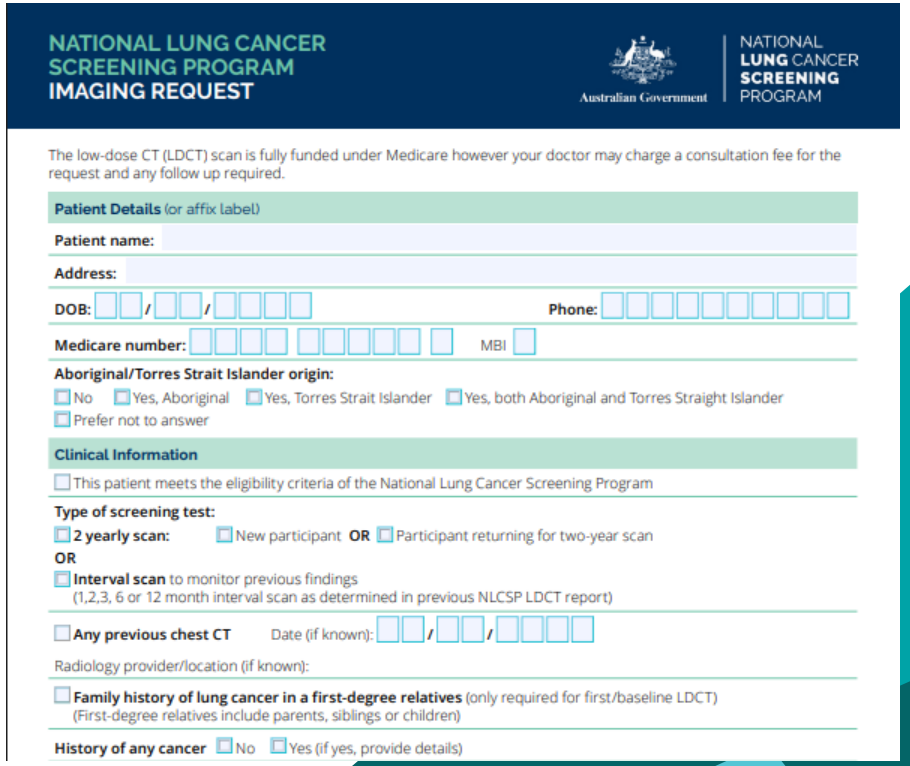
Current Smoker – 30 pack-year

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

ELIGIBILITY

CLINICAL NOTES

Doctor



NATIONAL LUNG CANCER SCREENING PROGRAM IMAGING REQUEST

Australian Government

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 Straight 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)

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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

Workforce implications:

- 73% of radiologists work at least part time in private practice
- Only 5% of radiologists have subspecialty training in chest
- 88% of radiologists perform at least some general work

chest scan

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Radiologist Role

	Program entry and supporting choice	Low-dose CT scan and reporting	Management of results, follow-up and reminders
Radiologists	-	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
Radiographers	-	Perform low-dose CT scan	-

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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)

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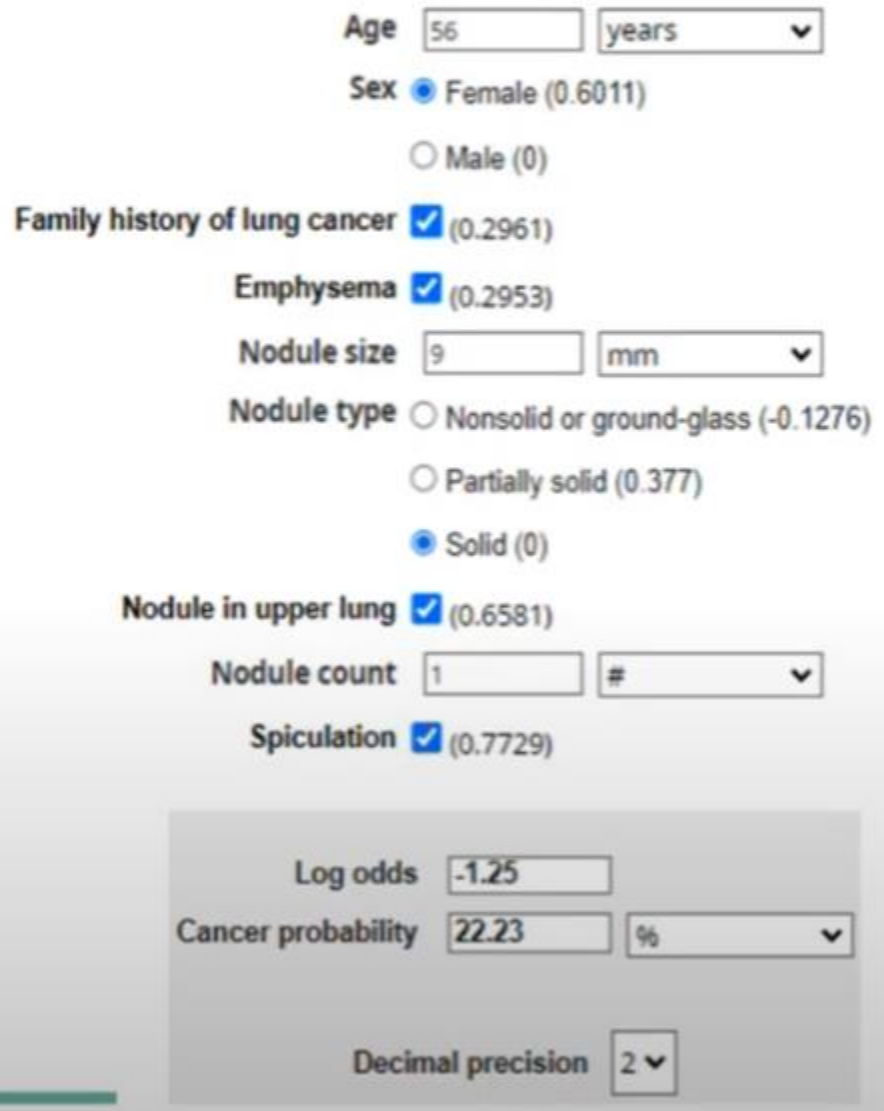
PanCan Nodule Malignancy Risk Calculator

Optimised selection of
low- and high-risk categories:

75.2% to 24m LDCT (not 12m)

2.8% cf 7.4% requiring referral



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)

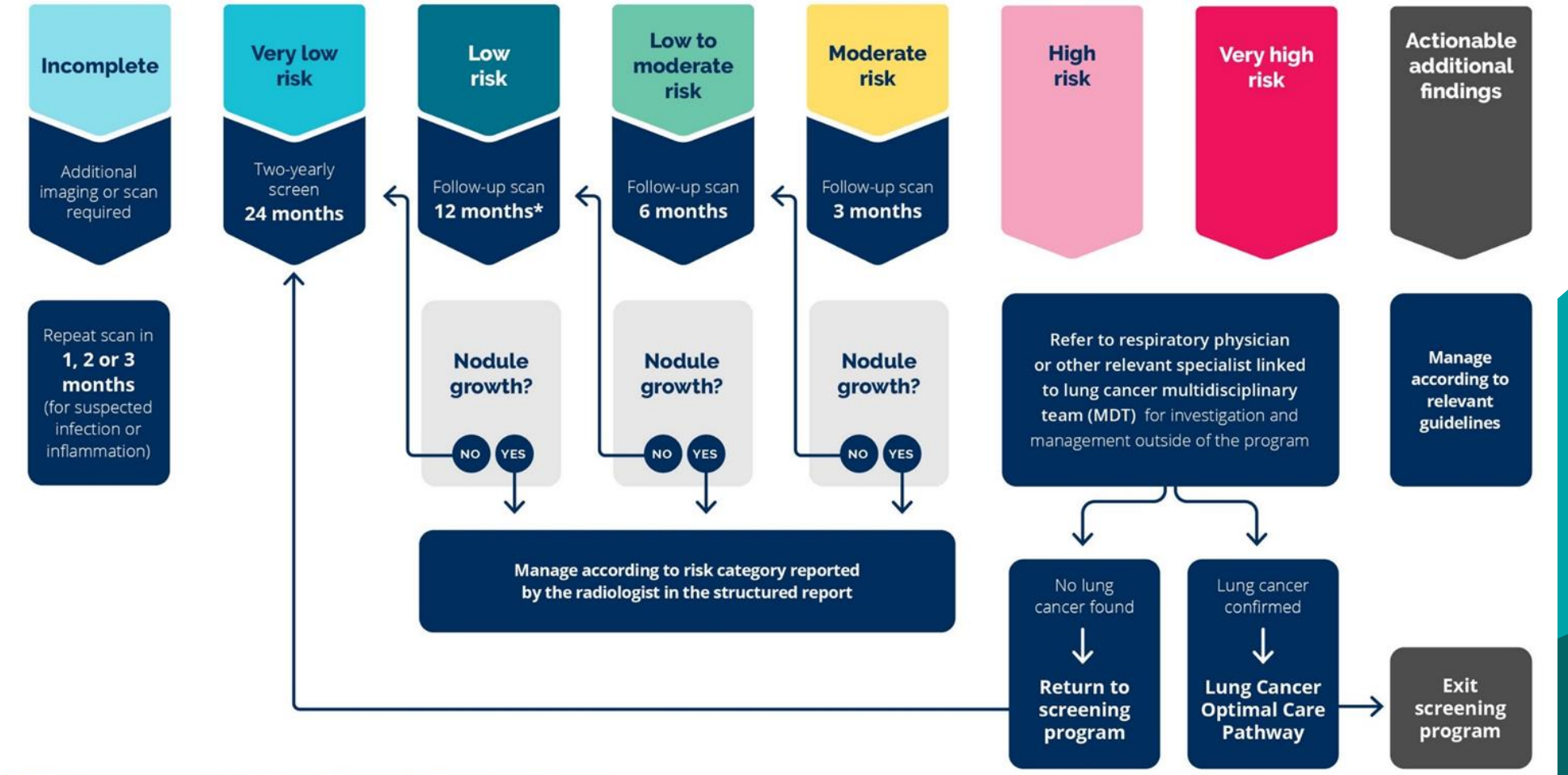
PanCan Nodule Malignancy Risk Calculator

- 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%	1.5 – < 6%	6 – < 10%	10 – < 30%	≥ 30%
24-month LDCT	12-month LDCT	6-month LDCT	3-month LDCT	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
≥ 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

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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 two-yearly 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 follow-up scan in 12-months 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 **follow-up scan in 3-months** 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 **Referred to a respiratory physician*** linked to a lung cancer multidisciplinary team (MDT) Remain in program whilst investigations are underway.

Results

Very 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 Referred to a respiratory physician* linked to a lung cancer multidisciplinary team (MDT) Remain in program whilst investigations are underway.
Actionable additional findings	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).	Receive correspondence to discuss results with healthcare provider Actionable additional findings investigated according to relevant clinical guidelines and usual care arrangements Refer to Actionable additional findings and Program exit and re-entry sections to understand whether the participant will remain in the program or whether they will exit/pause participation.

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
Incomplete	Findings suggestive of an inflammatory or infectious process	1-, 2-, or 3-month LDCT	0
Very low risk	No lung nodules	24-month LDCT	1
	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: • Complete, central, popcorn, or concentric ring calcifications • Fat-containing		
	Solid nodule: New < 34 mm^3 (< 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)		
Low risk	Previous Category 2 lesion that is stable or decreased in size over a period of less than 24 months	12-month LDCT	2
	Previous Category 3 lesion that is stable or decreased in size at 6-month follow-up LDCT		
	Airway nodule, subsegmental – new		
	Juxtapleural nodule: • New 524 mm^3 (<10 mm) AND • Solid; smooth margins; and oval, lentiform, or triangular shape		
	Non-solid nodule (ground glass): • < 14,137 mm^3 (< 30 mm): New or growing • ≥ 14,137 mm^3 (≥ 30 mm): Slowly growing		
Low to moderate risk	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	3
	Atypical pulmonary cyst: • Growing cystic component (mean diameter) of a unilocular thick-walled cyst		
	Solid nodule: • New 34 to < 113 mm^3 (4 mm to < 6 mm)		
	Part solid nodule: • New < 113 mm^3 (< 6 mm total mean diameter)		
	Non-solid nodule (ground glass): • ≥ 14,137 mm3 (≥ 30 mm) new or growing		
Moderate risk	Airway nodule, segmental or more proximal - new	3-month LDCT	4
	Atypical pulmonary cyst: • Newly multilocular cyst that was previously unilocular • New atypical pulmonary cyst of any morphology		
	Solid nodule: • Growing < 268 mm^3 (< 8 mm) OR		

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: • Thick-walled cyst with growing wall thickness/nodularity OR • Growing multilocular cyst (mean diameter) OR • Multilocular cyst with increased loculation or new/increased opacity (nodular, ground glass, or consolidation)		
	Solid nodule: • New or growing ≥ 268 mm^3 (≥ 8 mm)		
	Part solid nodule: • New or growing ≥ 34 mm^3 (≥ 4 mm) solid component		
	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

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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

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.

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 last demonstrated the previous trajectory should be used as the new comparison study.

#	Notes		
7	**Prior exams:** 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:		
	Any nodule stable for more than 24 months	Assign Category 1	
	Any 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

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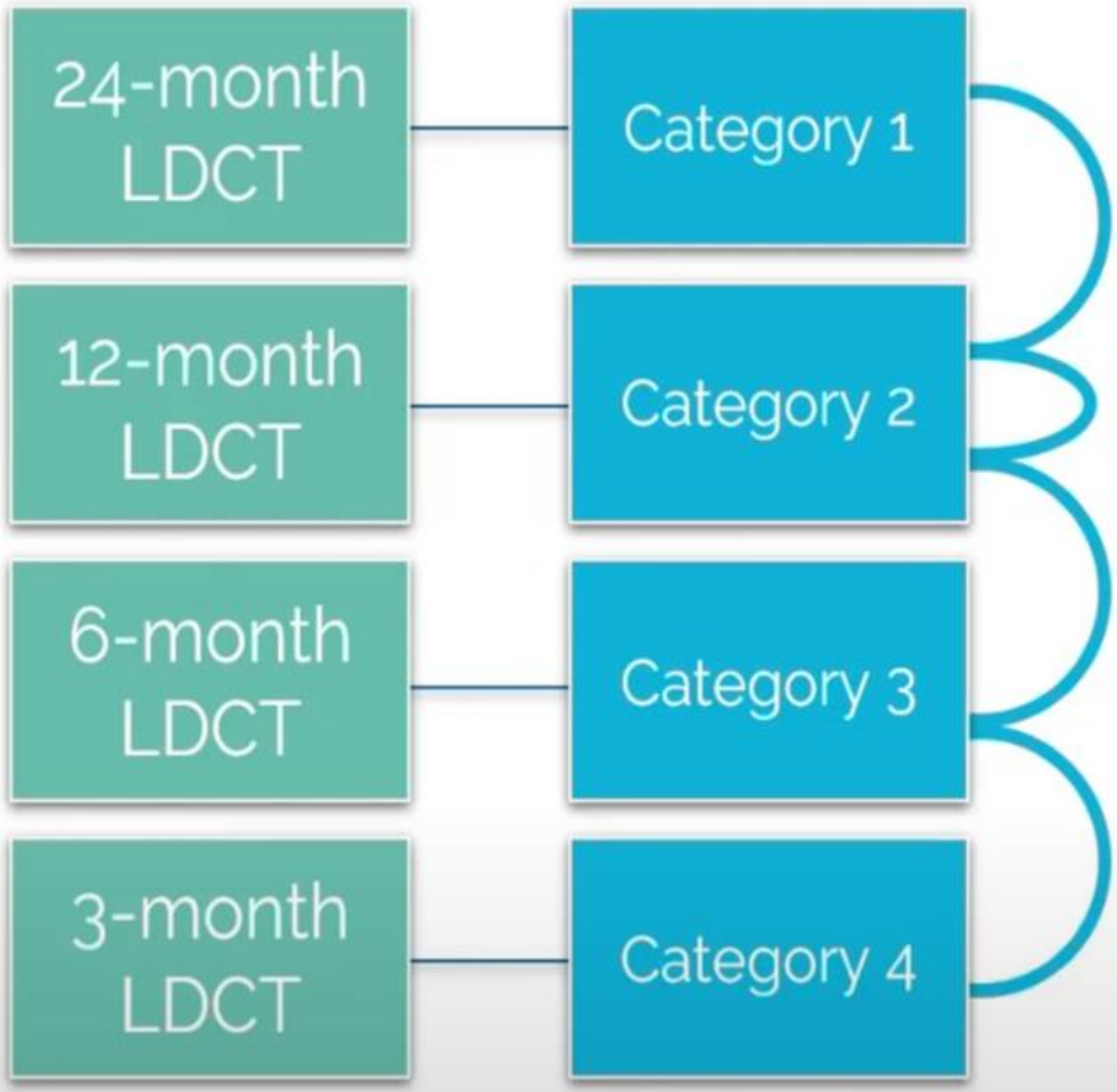

chest scan

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

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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

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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

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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

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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^3 (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.

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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^3 (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^3): 524
Volume, solid component (mm^3): 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.

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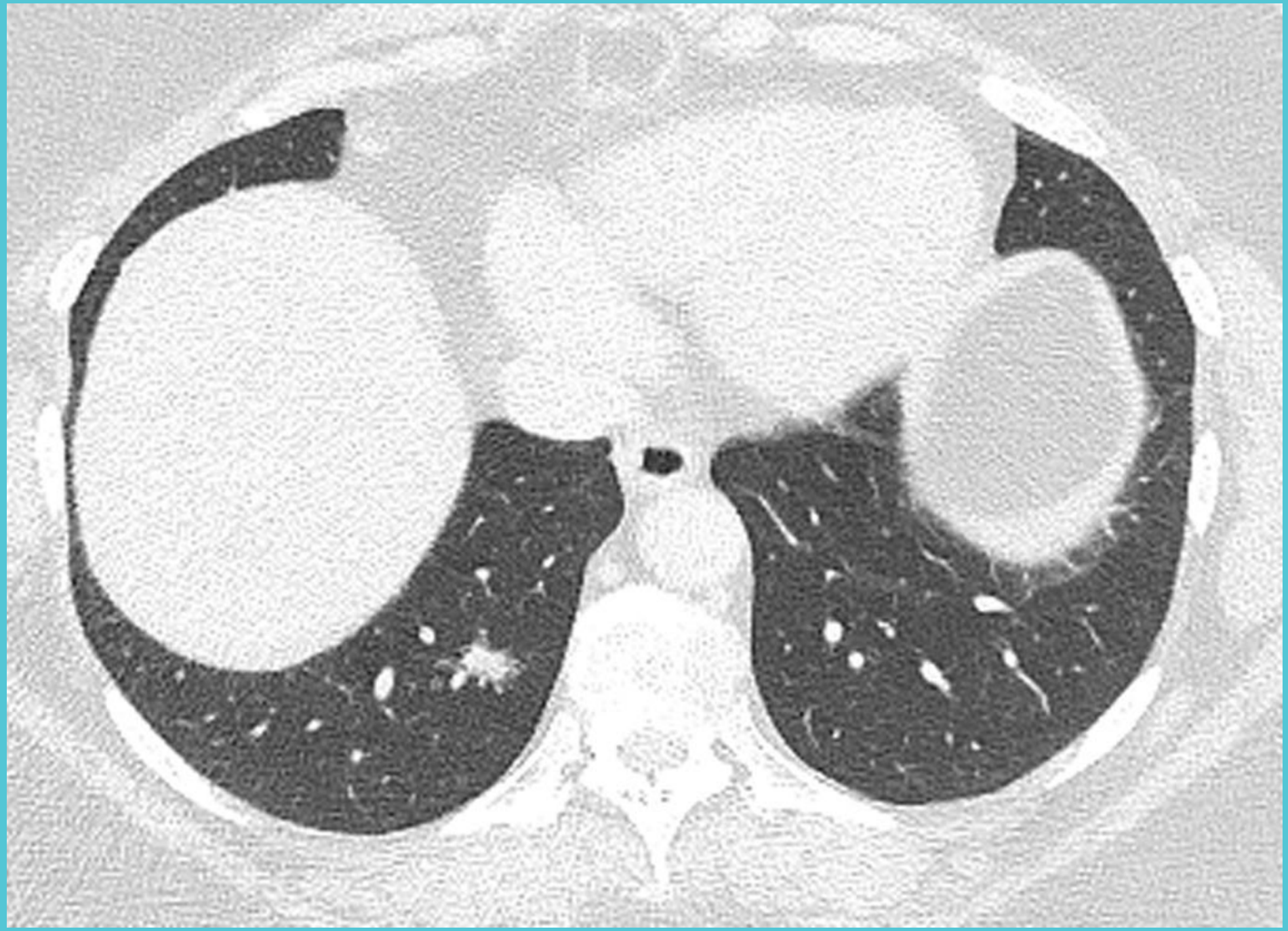
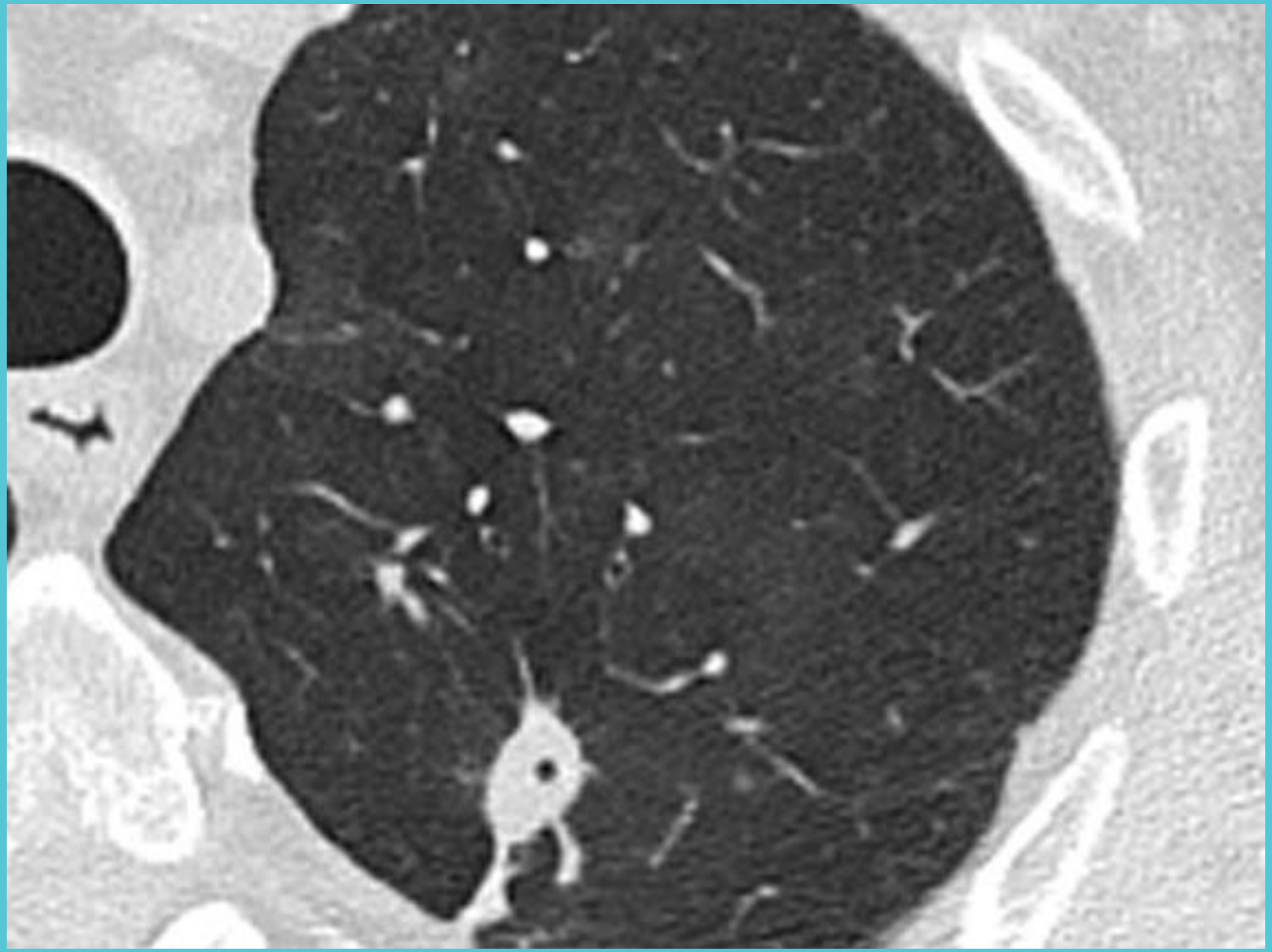
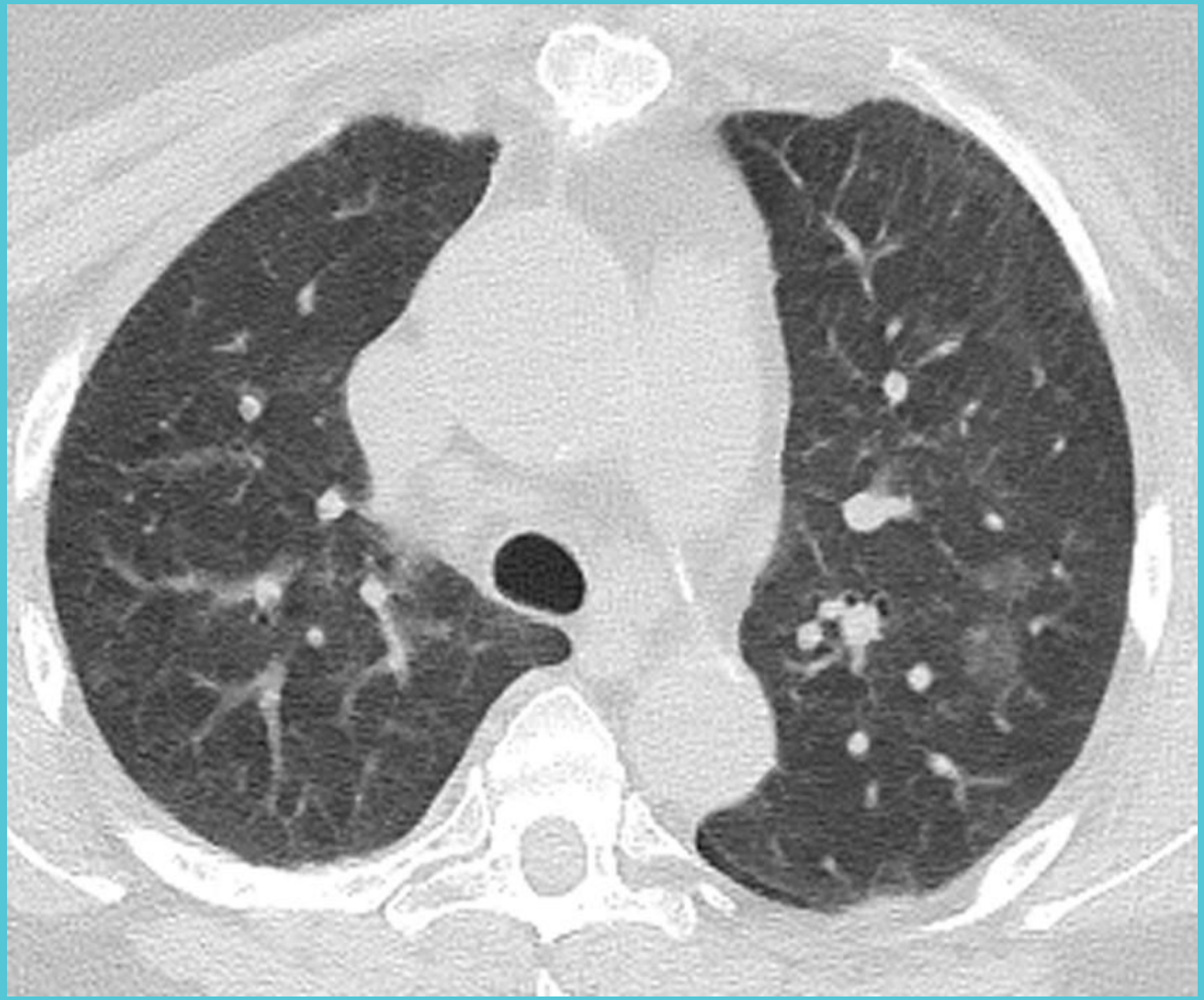
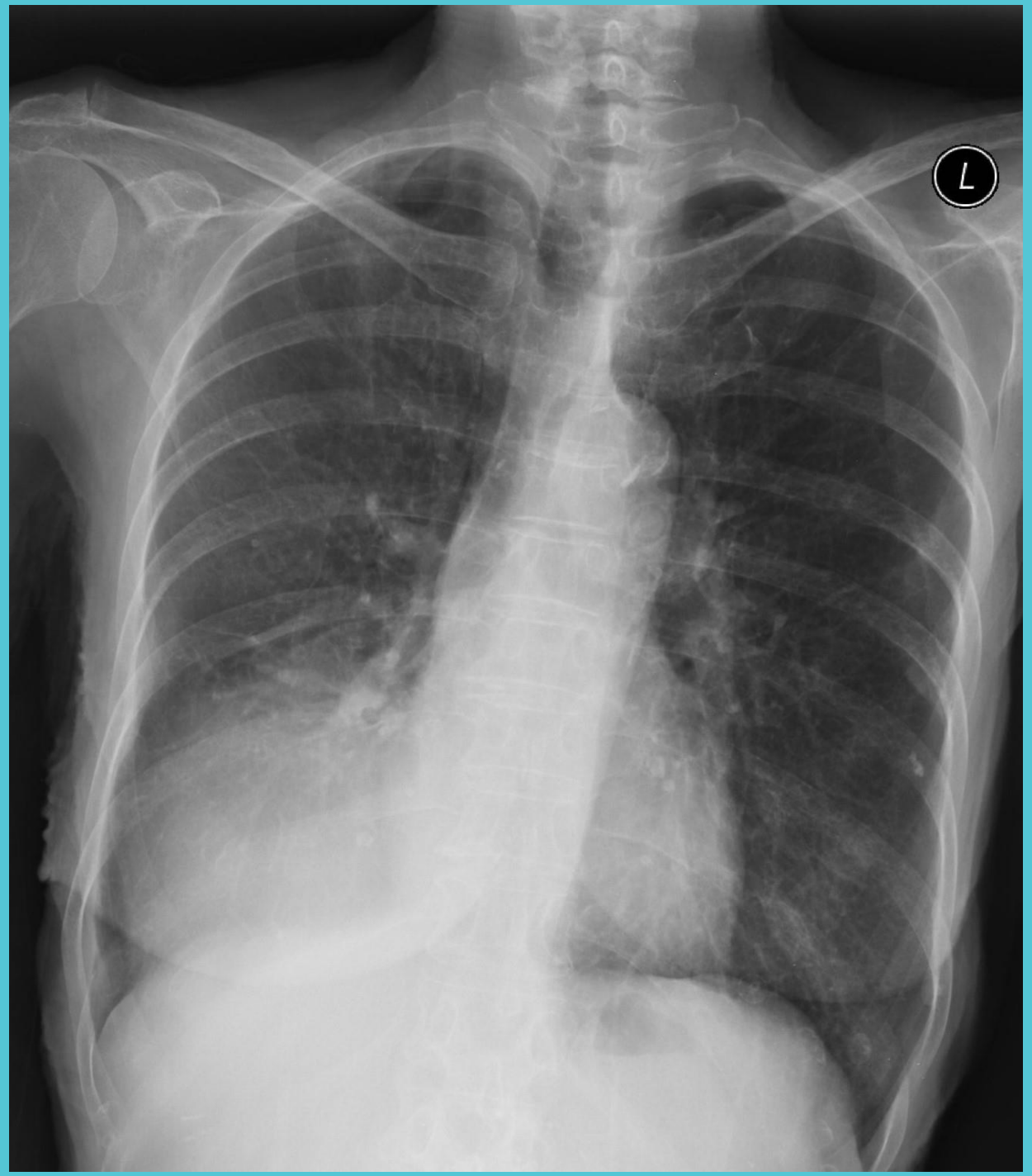
Images!!





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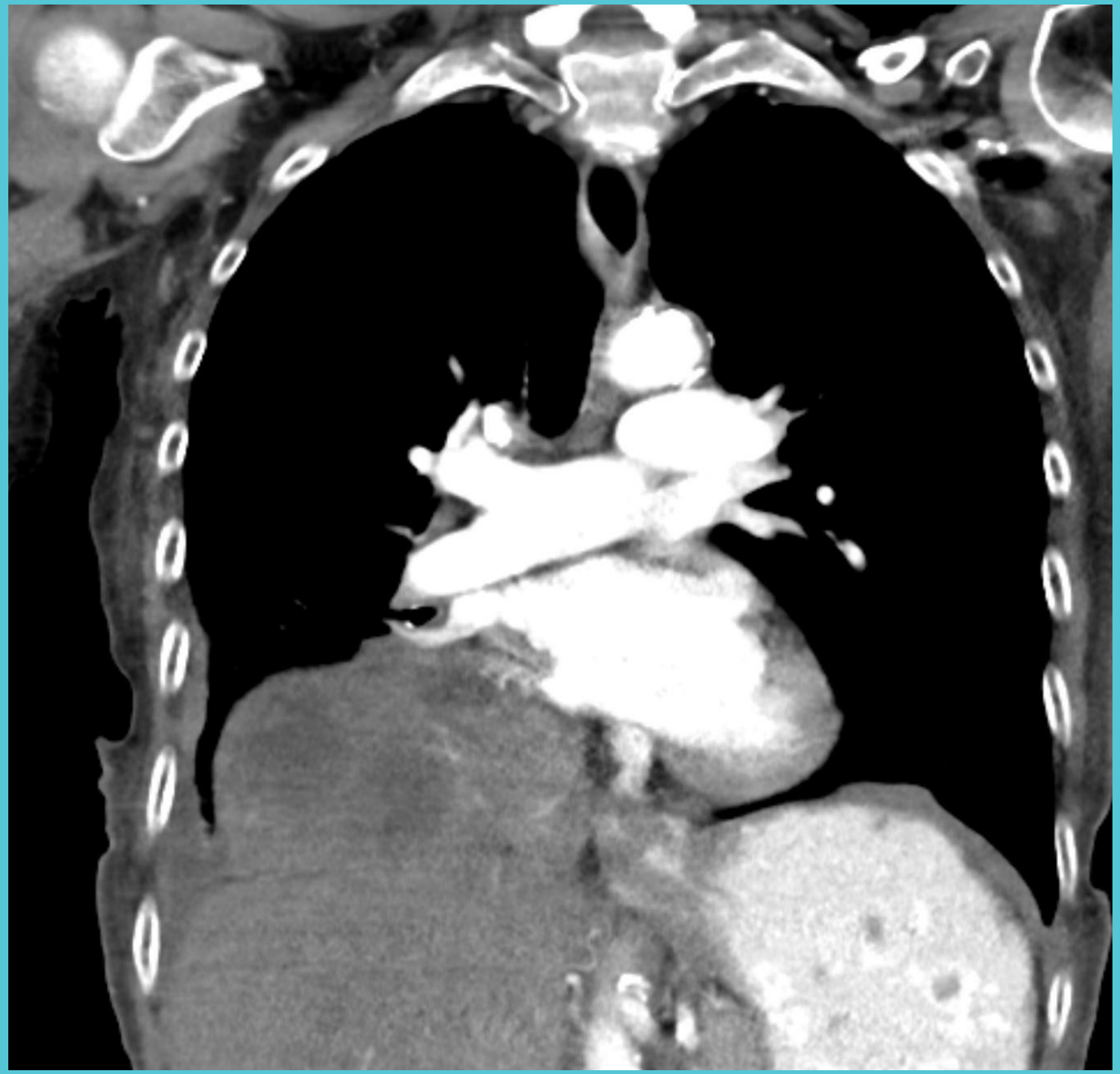
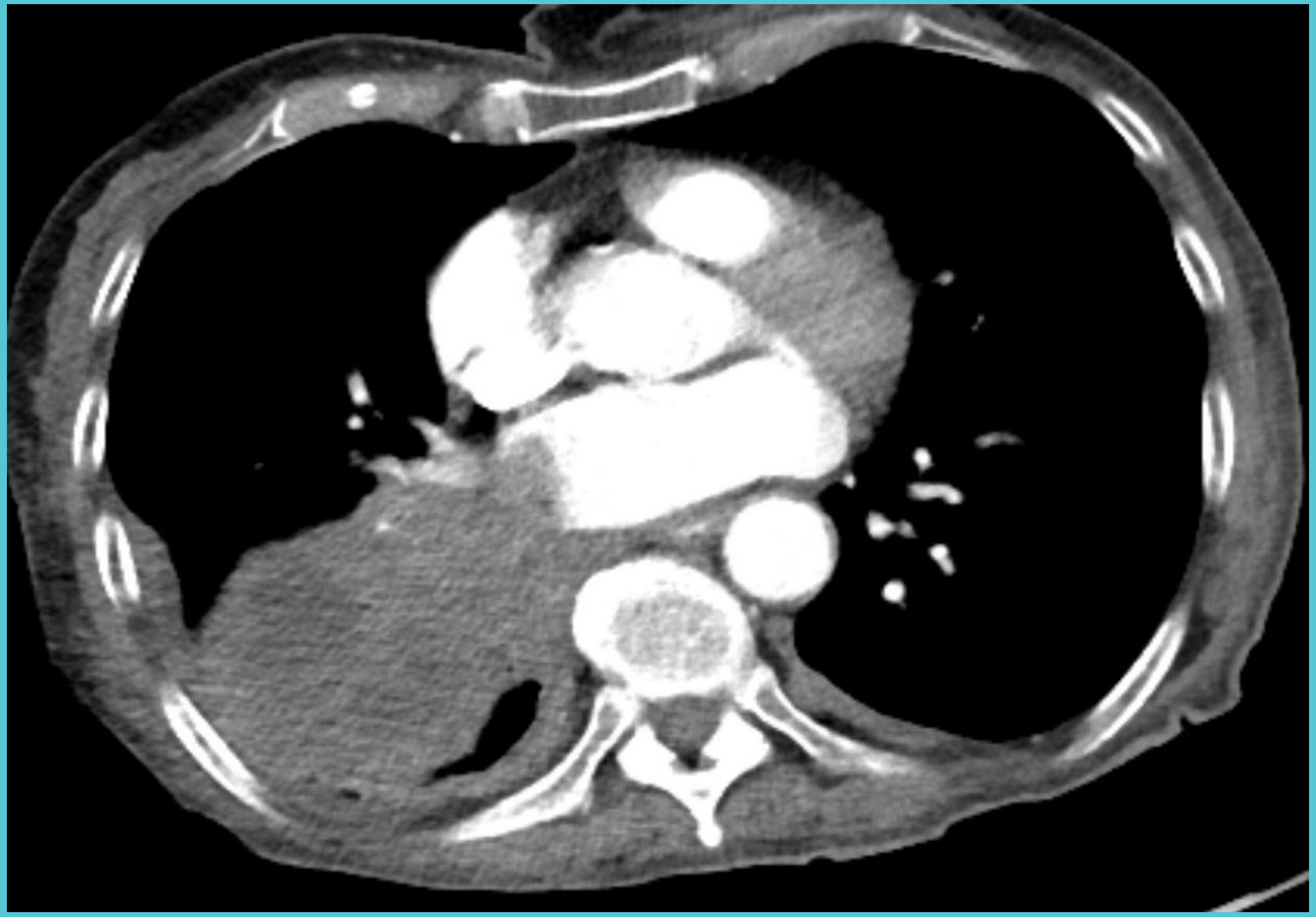
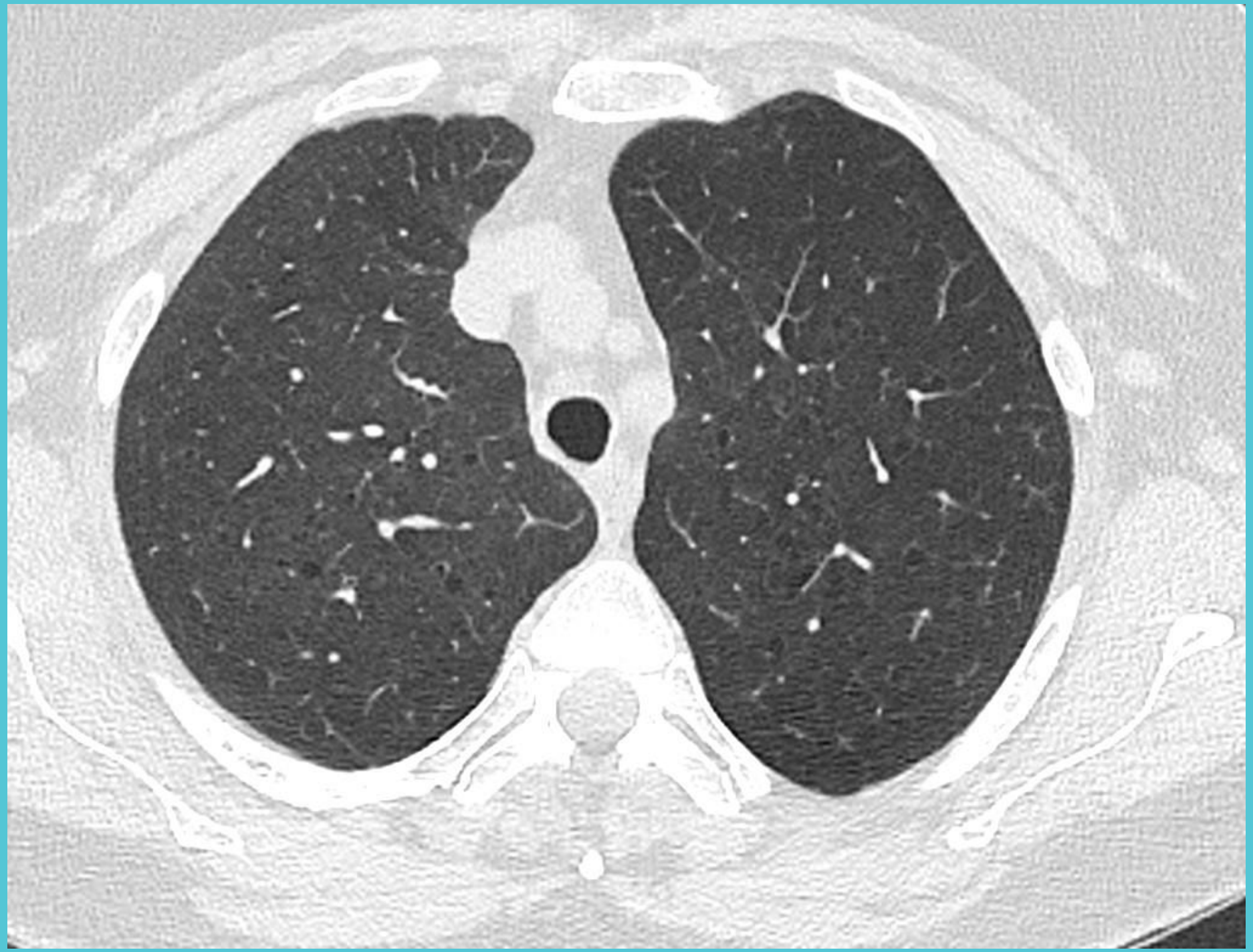
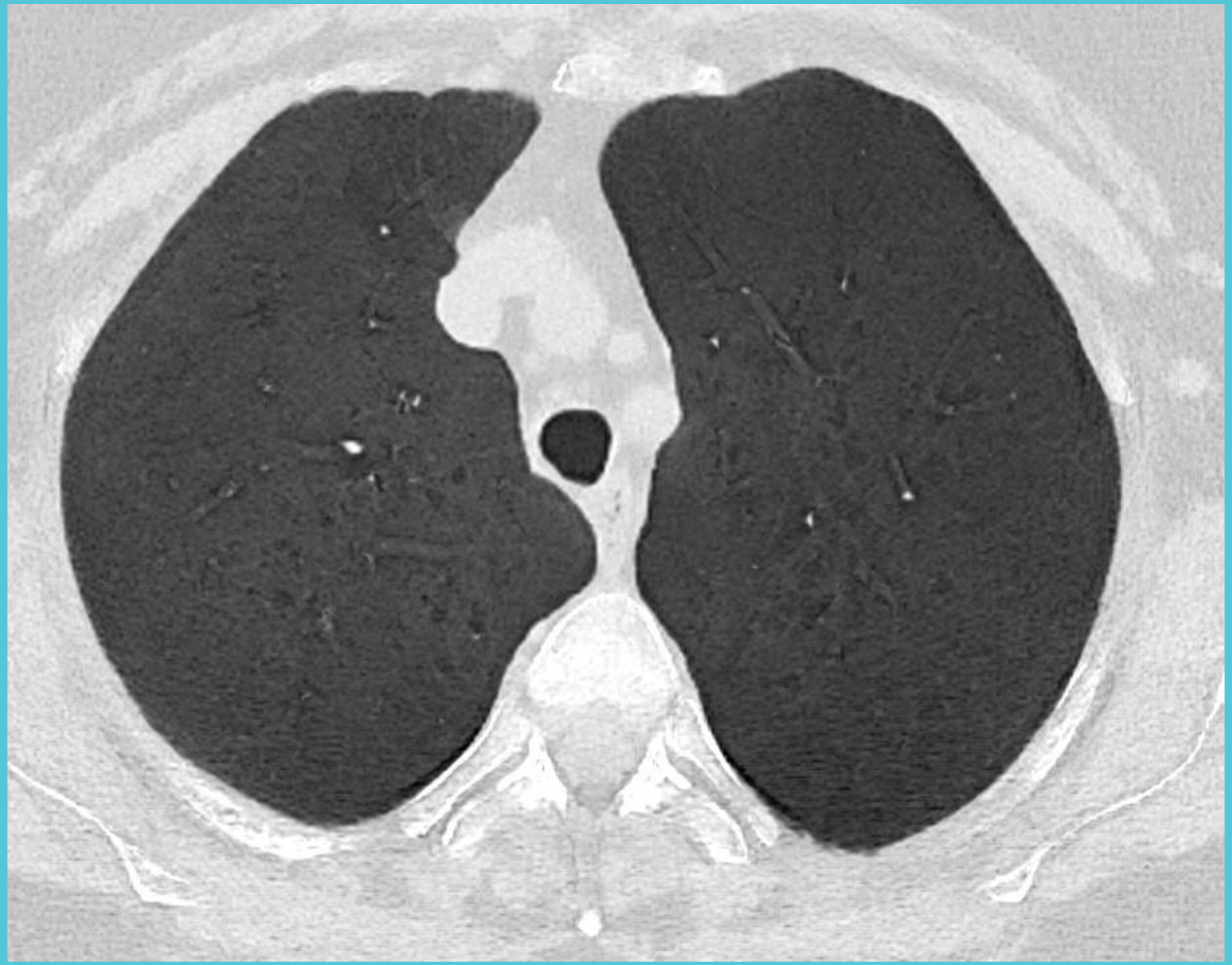
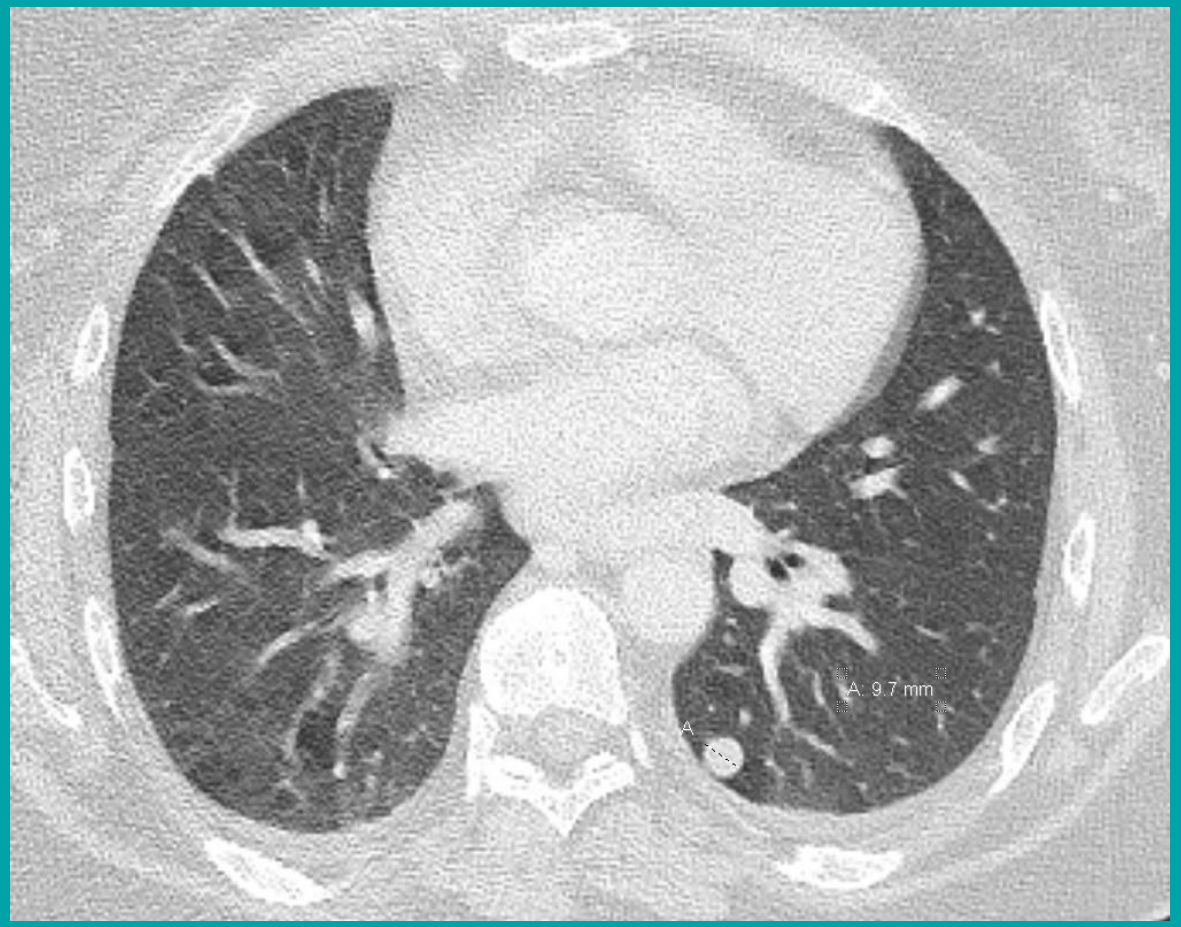








Index Scan



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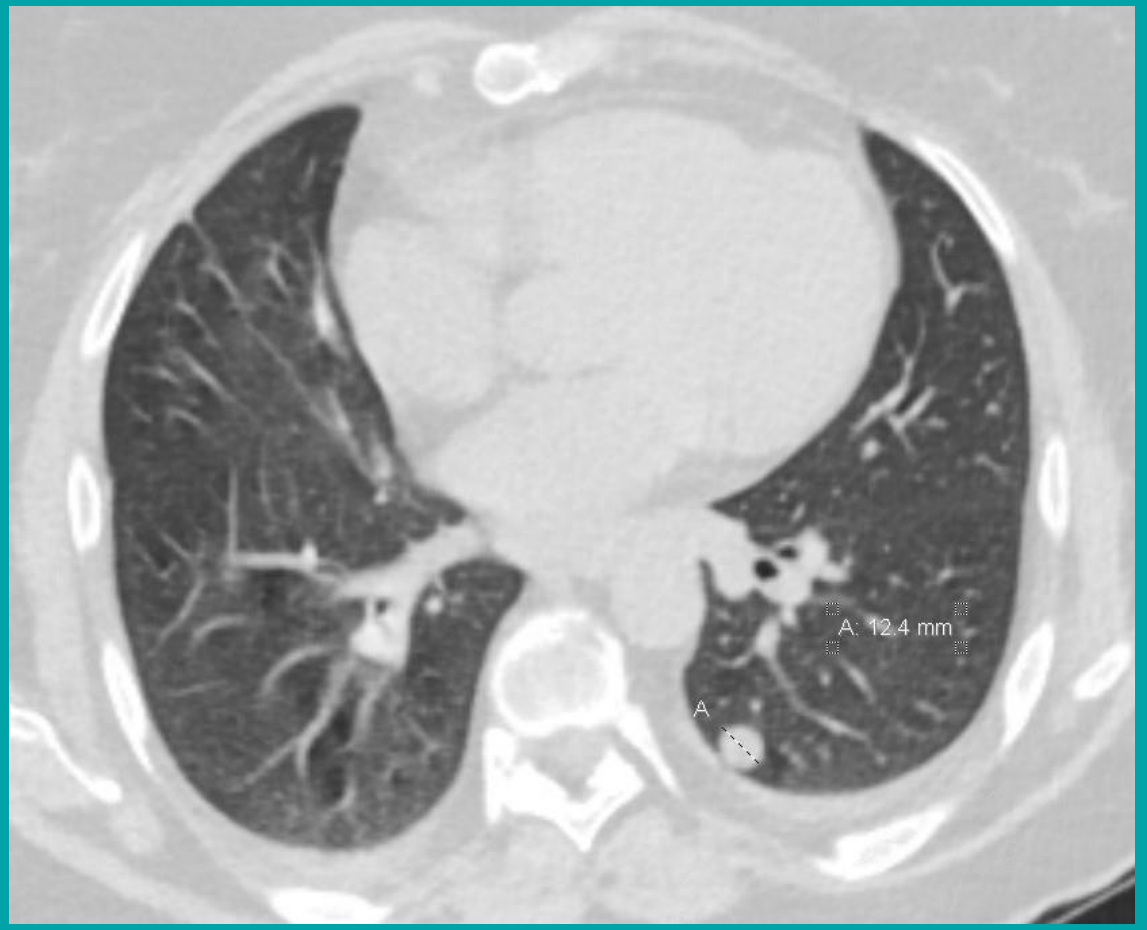
2 years later ...



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Growth trajectory

Volume-Doubling Time

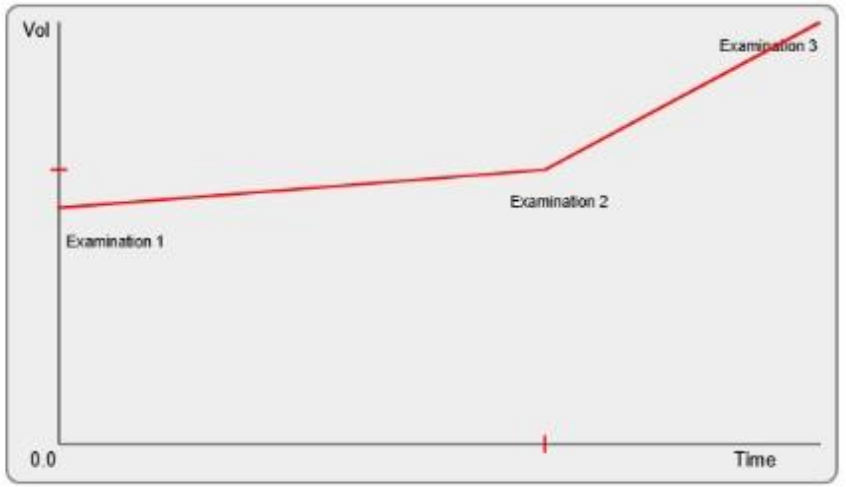
Online calculator for lung nodule volume-doubling time (VDT)

	Date	Dimensions	Volume (prism)	Volume (ellipsoid)
Examination 1	2023-08-09		0.578	
Examination 2	2024-08-23		0.671	
Examination 3	2025-03-27		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%



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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 **;**

- **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 patiets
  - Patient Pathways following reporting

chest scan

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Thank you for your attention

Dr Robin Harle

RHarle@idxgroup.com.au

Radiology Tasmania

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

MAIL HOUSE | **WEBSITE** | **DIGITAL CORRESPONDENCE**

NCSR CONTACT CENTRE | **PARTICIPANT PORTAL**

General Public

PARTICIPANTS

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)

BUSINESS INTELLIGENCE (BI) & REPORTING PORTAL

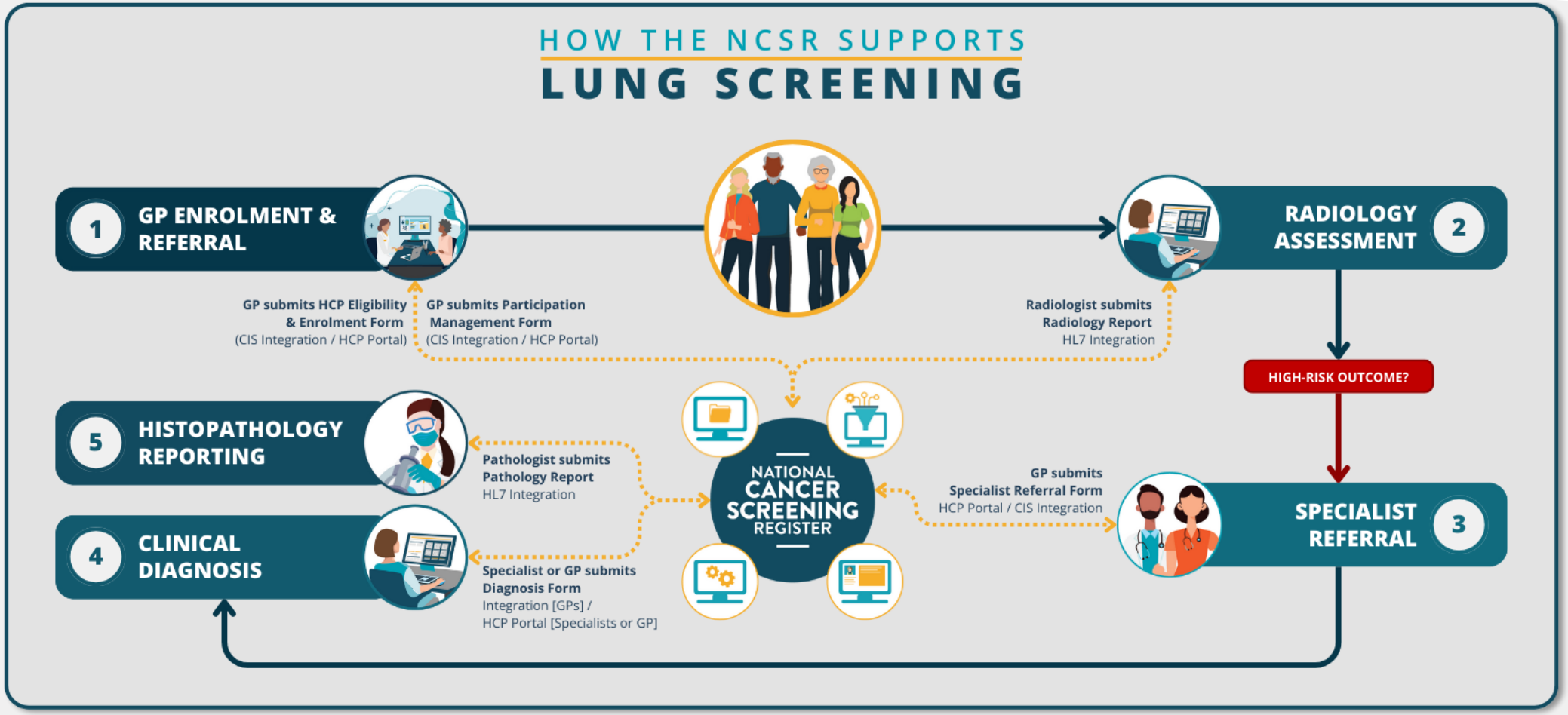
Commonwealth & AIHW Authorised Users

OTHER GOVERNMENT INTEGRATIONS

myGov
PRODA
Medicare
PDS

Doc. Verification Service
HI Service
NASH PKI

NCSR SOLUTION OVERVIEW



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

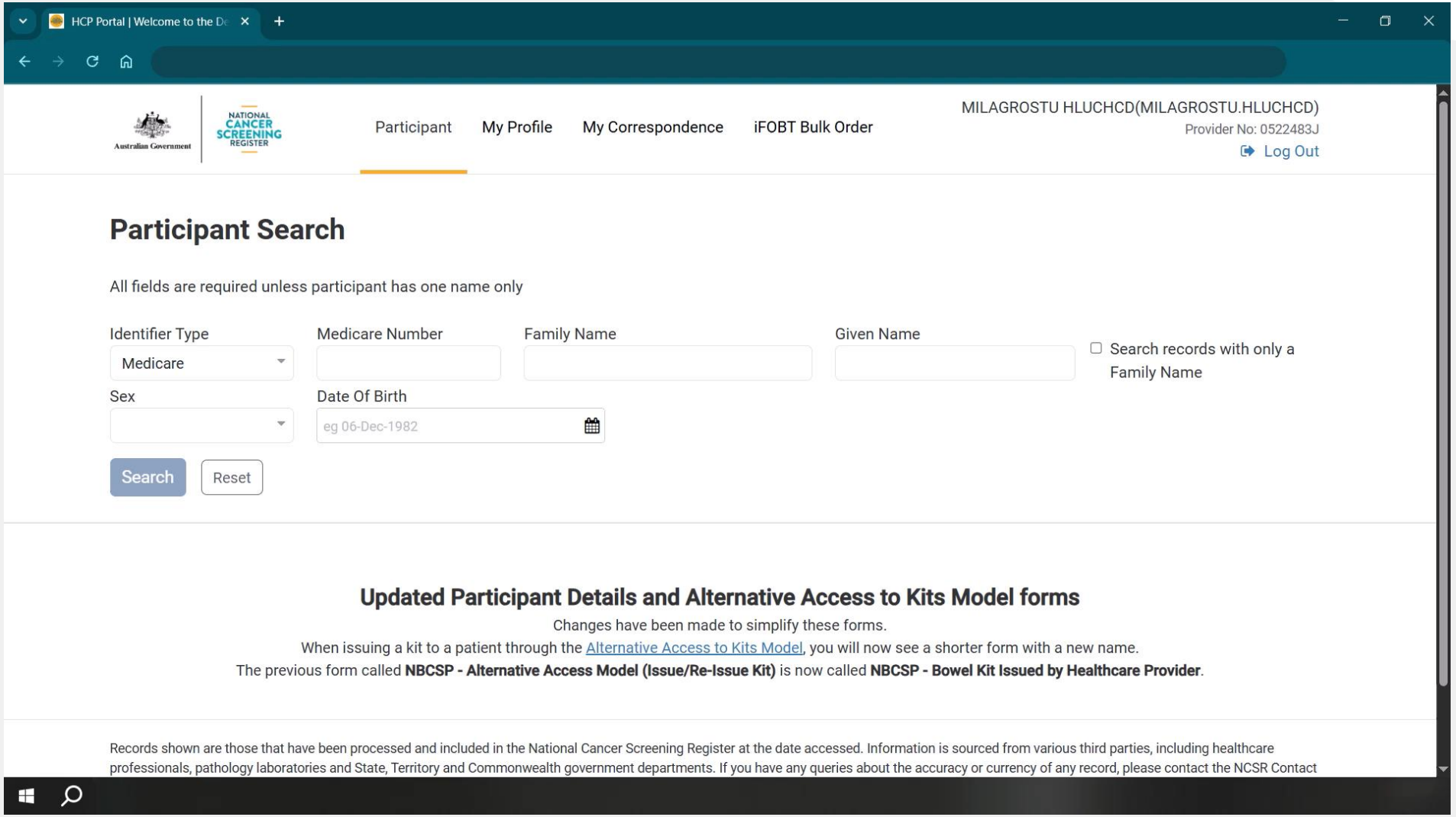
Manage patient's details and preferences

Order Bowel Screening Test Kits

Accessed via PRODA or integrated clinical software

Australian Government

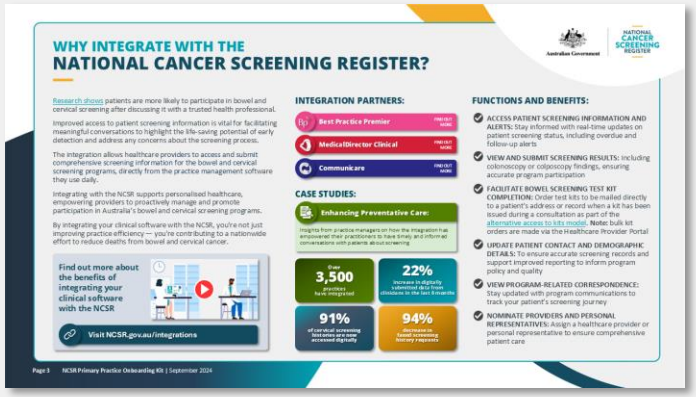
NATIONAL CANCER SCREENING REGISTER

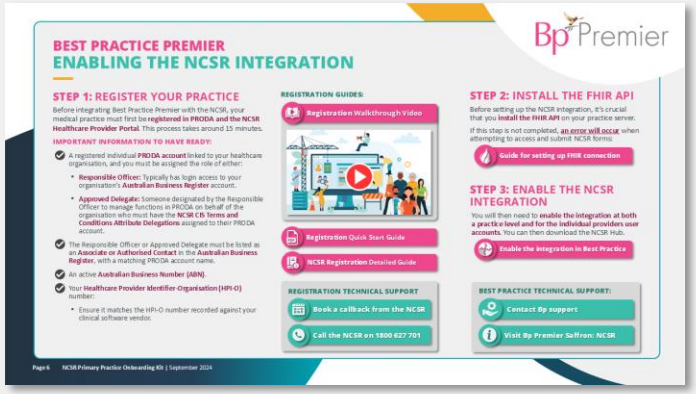

HCP Portal | Welcome to the De
Australian Government
NATIONAL CANCER SCREENING REGISTER
Participant
My Profile
My Correspondence
iFOBT Bulk Order
MILAGROSTU HLUCHCD(MILAGROSTU.HLUCHCD)
Provider No: 0522483J
Log Out
Participant Search
All fields are required unless participant has one name only
Identifier Type
Medicare
Medicare Number
Family Name
Given Name
Search records with only a Family Name
Sex
Date Of Birth
eg 06-Dec-1982
Search
Reset
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

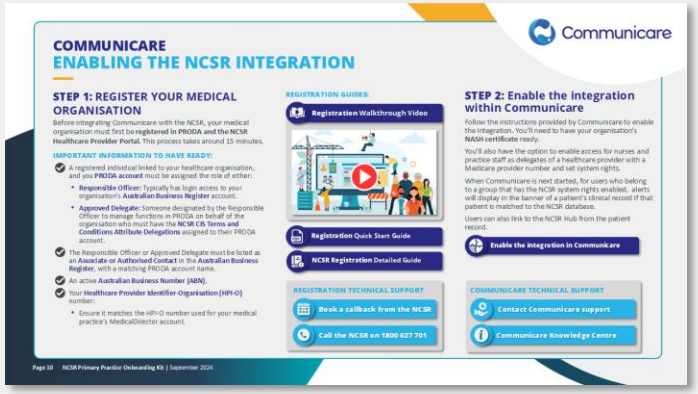
PRIMARY CARE ONBOARDING KIT

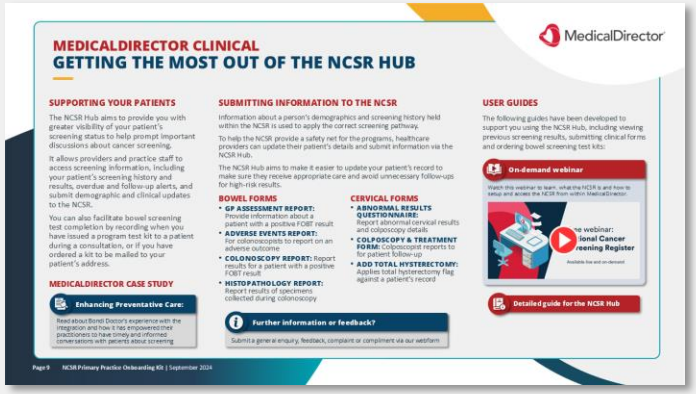
A guide to onboard healthcare organisations using compatible clinical software and help providers and staff make the most of the NCSR integration to support their patients in bowel and cervical screening.

View onboarding toolkit



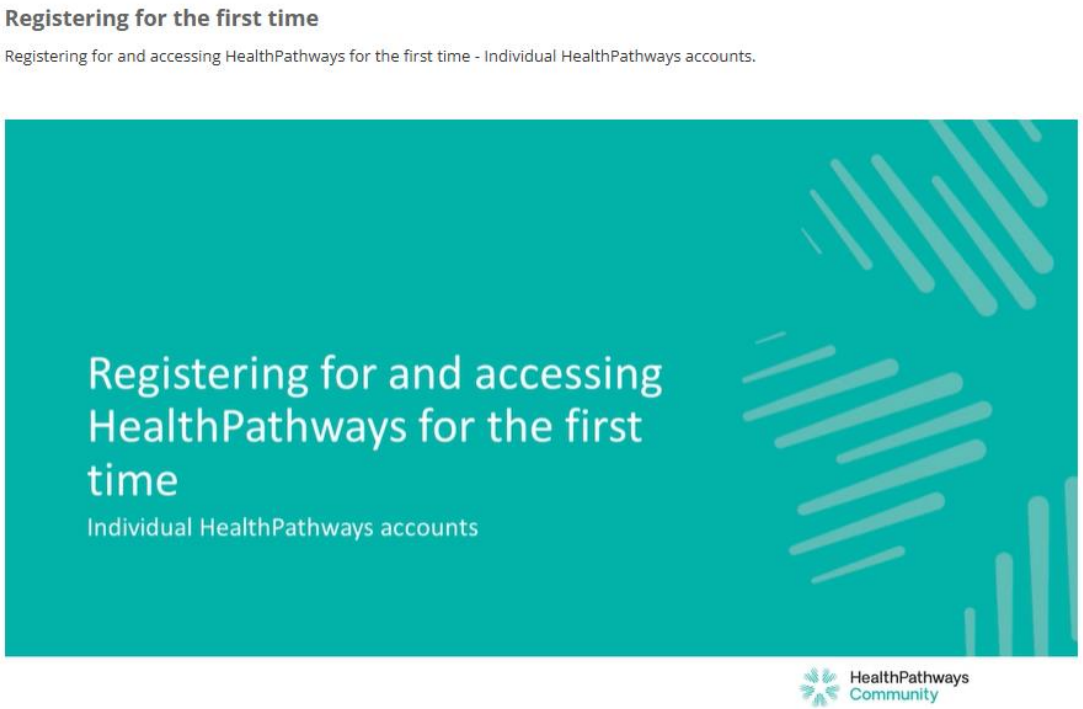






Tasmanian HealthPathways

Update- New personalised accounts



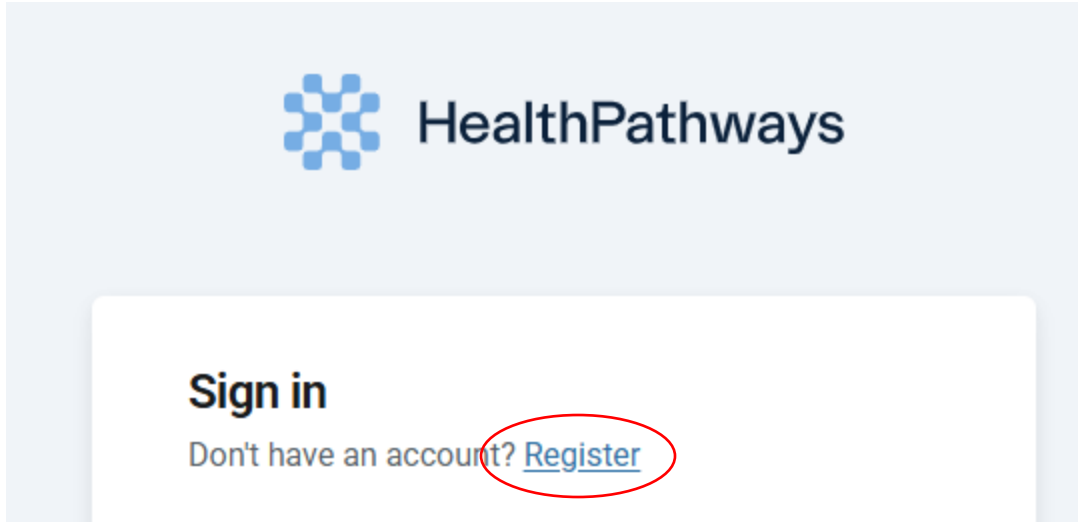
Scan to learn more

Have a question? Contact the Tasmanian HealthPathways team HealthPathways@primaryhealthtas.com.au

Tasmanian HealthPathways

Sign up for a personalised account today!

Scan to register now



The generic login will cease on Tuesday 1st July

Some final words

- After this webinar end, your browser will open a link to an evaluation survey.
- Statements of attendance will be emailed to participants.
- For event queries, please contact events@primaryhealthtas.com.au

Thank you

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