Reviewed: October 2022
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Metastasectomy Referral Form to Local Lung Cancer MDT

Please send to your local Lung cancer MDT **Date Email/Fax……**

NHS No:	**Consultant:**
Hosp. No **DOB:**	**Key Worker (Local Nurse Specialist)**
Name: **Address:** **Patient Tel No:**	**Cancer MDT referring** **MDT Date** **Lung Function Test: All patients for lung resection must have Full Lung Function Tests included with referral (If Attaching full report, No need to fill)** **FEV1- L %,FEV1/FVC TLCO KCO** **CPET-**

Primary Malignancy:

Management So far:

Is Primary Cured/Remission YES/NO Duration Since Control/Remission……..

Performance Status (Tick as appropriate): 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

Exercise Tolerance…….Limited by……..

CT Scan: ☐ Date: PET CT Scan: ☐ Date:

Total No of Nodules ( )

Right – RUL ( ) Left- LUL ( ) Other Important Findings
RML ( ) LLL ( ) 1……
RLL ( ) 2……
3……

Current smoker: Ex-smoker: Never smoked:

Alcohol History: None/ Social /Moderate/Heavy

Previous Medical History

IHD Y N ……..
CVA Y N ……
PVD Y N ……..
Asbestos exposure Y N

Antiplatelet/Anticoagulation Medication:
Other Medication

Last Chemotherapy

Alternative Treatments **Other relevant information:(e.g. <u>Specific MDT discussion, adjuvant treatment, i.e assessment only/ biopsy only/Lymph nodes etc</u>)**
Has the patient been informed of this referral? YES ☐ NO ☐

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The Pathway (Proposed.....)

Colorectal MDT primary MDT(Deciding benefit)

- Primary Control
- Dis free interval
- No of Met
- Initial Fitness
- Adjuvant/Neo-Adjuvant /Alternative treatment

Access initial suitability, decide Benefit and Refer

The Lung cancer MDT

- Fitness
- Distribution of Mets
- Respectability or Ablation
- Pri Lung cancer
- Lymph node involvement- Investigations

Pulmonary Metastasectomy Expert Consensus Statements

1. When caring for patients with cancer and pulmonary oligometastases, pulmonary metastasectomy (PM) should be considered within a multidisciplinary team (MDT) and carefully individualized.
2. In oncologically and medically appropriate non-small cell lung cancer (NSCLC) patients, tissue from PM should be sent for genomic/molecular analysis, including programmed death-ligand 1, to guide future therapies.
3. In oncologically and medically appropriate patients, PM can be considered with a preference for minimally invasive surgery (MIS) because of shortened postoperative recovery and lessened effect on quality of life.
4. If goals of R0 and pulmonary parenchymal sparing are not accomplishable by MIS but lend themselves to open approaches (thoracotomy, sternotomy, or clam shell), open techniques are appropriate.
5. Pneumonectomy to accomplish PM is discouraged except in carefully selected patients undergoing MDT management.
6. Although the absolute number of pulmonary metastases is not a direct contraindication to PM, candidate selection for PM is best suited to patients harboring 3 or fewer pulmonary metastases.
7. Lymph node (LN) sampling/dissection concomitant with PM should be considered, because pulmonary metastasis accompanied by mediastinal LN metastasis predicts poor survival.
8. Thermal ablation or stereotactic ablative body radiotherapy (SABR) is reasonable therapy for patients with pulmonary oligometastases, particularly for patients considered high risk for resection or who refuse resection.
9. Outside of clinical research, isolated lung perfusion is not warranted for management of pulmonary metastases.
10. In colorectal cancer patients, PM can be considered within an MDT construct with systemic therapy before or after PM.
11. In renal cell carcinoma patients, PM can be considered within an MDT construct.
12. In malignant melanoma patients, PM can be considered within an MDT construct.
13. In sarcoma patients, PM can be considered within an MDT construct.
14. PM in management of primary head and neck cancer can be considered in the context of a disease-free interval (DFI) exceeding 12 months, ability to completely resection, and absence of LN metastases.
15. When managing nonseminomatous germ cell tumors (NSGCTs), PM is indicated for all residual lung abnormalities $\geq$ 10 mm after platin-based chemotherapy with normalized serum tumor markers (STMs) suspected of containing teratoma.
16. When managing NSCGTs, contralateral lung abnormalities can be observed if histology of unilateral PM demonstrates complete tumor necrosis.