

Lack of an Established Pathway When Evaluating a Suspicious Lung Mass

Potential Action Items

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- Monitor lung cancer patient data obtained from imaging reports, pathology reports and surgical reports, to include size of lesion, location of lesion and mode of biopsy to see if there are patterns that drive mode of biopsy decisions
- Include information about a lung “hotline” to report abnormal chest x-ray and CT scan reports for radiology charts
- Include lung “hotline” information on patient instruction forms for chest x-ray or CT scan

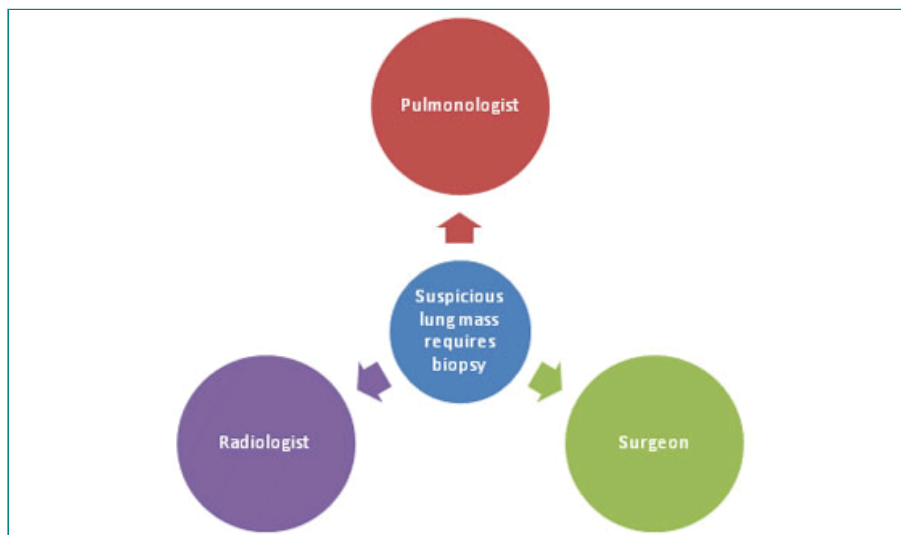
Ideas for Process Improvement

In the community, the evaluation of a suspicious lung mass may follow a wide range of pathways depending on which physician is leading and coordinating the diagnostic workup. The process becomes especially challenging when a lung biopsy is needed to establish a diagnosis. Since there are usually several types of physician specialists who can perform a lung biopsy, who should perform the initial biopsy? A pulmonologist? Radiologist? Or surgeon?

Needle biopsy methods generally include:

- Fine-needle aspiration (FNA)—which may be performed by radiologists or pulmonologists
- Core-needle biopsy (CNB)—which are only performed by radiologists (due to needle size and flexibility)

In general, CNB yields larger segments of tissue (histology) that are better suited for molecular testing, FNA yields fluid and cells (cytology) and when the sample is adequate, the pathologist can create a cell block for molecular testing analysis. This often requires several samples during an FNA biopsy procedure.



Learning lab participants spent some time discussing how their physicians were making biopsy decisions. Most centers agreed that a pulmonologist should be the one who is coordinating the diagnostic workup and discussing potential biopsy approaches with radiologists and surgeons if they are unable to perform a bronchoscopy-guided biopsy. However, several centers participants also noted that they do not have enough pulmonologists to manage their volume of patients who may have lung cancer. Therefore, their radiologists performed the majority of lung biopsies using CT-guided needles.

Some centers had established effective ways of communicating with outpatient primary care providers to ensure that patients with suspicious lung masses were sent to their “nodule clinic” for further diagnostic workup and appropriate

follow-up. One center uses a highly visible lung “hotline” phone numbers so that patients and primary care providers know who to call if they encounter an abnormal CT scan result. This lung hotline phone number is printed on CT scan instruction forms, test results, radiology reports, and other key documents. Other centers had a routine process of having an interdisciplinary team of physicians discuss and determine the optimal approach for biopsy.

The goal of the lung biopsy is evolving and this needs to be communicated to primary care providers. What was once a routine procedure to simply establish a diagnosis is now becoming a procedure to obtain adequate tissue for diagnosis plus molecular testing. More tissue is now needed, so it is critical to identify the optimal approach when the initial biopsy is performed.