

Abstract for submission to the 16th Annual British Thoracic Oncology Group (BTOG)

Conference 2018; Dublin, 24-26th January 2018

Submission deadline: Sunday 1st October 2017

Preferred method of presenting (poster and oral presentation / poster only)

Topic (select one): Clinical Networks & Pathways.

The following will need to be declared at the time of submission:

- I confirm that the submission is original and previously unpublished (nurses can submit poster abstracts to BTOG 2018 previously submitted to NLCFN 2017). BTOG 2018 Abstracts will be published in a supplement - Lung Cancer. Please note that submission of an abstract implies consent by the authors for inclusion in the supplement.
- I confirm that at least one author will register for BTOG 2018.
- I declare that the abstract content has not been presented at another meeting.

Disclosures

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Wasat Mansoor: no conflicts of interest.

Stuart Ferguson: employee of Novartis Pharmaceuticals UK Limited.

Denis Talbot: has received honoraria and support for educational activities from Novartis and Ipsen.

Title: *The incidence, diagnostic pathway and management of pulmonary carcinoid tumours in the UK: Results from the National Lung NET pathway ('LEAP') Project*

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Abstract (max 300 words plus one diagram, table or picture). Current word count = 298

Introduction/background: Pulmonary carcinoid (PC) tumours are rare and published data on UK epidemiology and management is limited. The LEAP Project aimed to describe the incidence, diagnostic pathways and management of PC in the UK to improve understanding of current pathways.

Methods: Between October 2016-May 2017 interviews were conducted with 27 clinicians at 27 UK centres, including all ten UK European Neuroendocrine Tumor Society (ENETS) Centres of Excellence.

Results: Respondents comprised 13 medical oncologists, 6 clinical oncologists and 8 other specialists from centres with approximately 2-80 new PC patients/year. For 12/16 evaluable centres the estimated number of new patients/year was lower than would be expected (based on hospital catchment population and expected incidence of 1.49/100,000 population [Dasari, 2017]). The estimated proportion of patients presenting with advanced (unresectable/metastatic) disease (median) was 10% for typical (TC) and 30% for atypical (AC) carcinoid tumours. 16/27 respondents (59%) had a NET clinical nurse specialist and 25/27 (93%) a NET-specialist MDT meeting available to their PC patients.

Aside from routine baseline biochemical tests (e.g. 5-hydroxyindoleacetic acid, chromogranin A), other assessments included Ki67 scoring (21/27, 78%) and functional imaging (fluorodeoxyglucose positron emission tomography [PET] [22/27, 81%], octreotide scan [18/27, 67%], gallium PET [10/27, 37%]).

Regarding therapy, the number of respondents who would consider adjuvant treatment post-surgery in fully-resected TC patients was 4/27 (15%) for N1M0 disease, 8/27 (30%) for N2-3M0 and

11/27 (41%) for R1-resected; 9/27 (33%), 13/27 (48%) and 13/27 (48%), respectively, for AC. Table 1 shows treatments used for advanced disease.

Conclusions: This UK-wide survey provides valuable insights into the incidence, diagnostic pathways and current management of PC. The data highlights an apparent lack of consensus among clinicians on a number of aspects relating to diagnosis and treatment. Adoption of ENETS guidance, published in 2015 (Caplin, 2015) may help to standardise patient pathways.

Table 1: First, second and third line treatments for patients with advanced disease

Treatments used*	Number (%) of respondents (n=27)		
	First line	Second line	Third line
Somatostatin analogue	17 (63%)	5 (19%)	2 (7%)
Chemotherapy	3 (11%)	9 (33%)	11 (41%)
Surgery	6 (22%)	-	1 (4%)
Mammalian target of rapamycin inhibitor / targeted therapy	1 (4%)	7 (26%)	3 (11%)
Radiotherapy	-	2 (7%)	1 (4%)
Peptide receptor radionuclide therapy	-	3 (11%)	5 (19%)
Interferon	-	-	1 (4%)
Clinical trial	-	1 (4%)	1 (4%)
Not known / no response / refer elsewhere	3 (11%)	2 (7%)	5 (19%)

** Factors reported by respondents to influence treatment choice included: rate of progression, presence of metastases, functionality and location of disease, tumour type and volume, Ki67 score, symptoms, treatment availability.*