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Saturday, June 10, 2017

15:10 - 15:35 Primary and Secondary Healthcare Interface

Supported by:



Primary and Secondary Healthcare Interface – How Working Together Helps Our Patients

Rotorua GP CME

10 June 2017



TUAPAPA PŪKAHUKAHU
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What Are the Issues?

A Hospital Physician's Perspective

- Respiratory problems are common, & a common cause of presentation to primary care
- Referrals from primary to secondary care are also common
- Need to ensure that we have a collaborative approach
 - Ensure those with urgent problems are seen urgently
 - Appropriate advice/ management guidelines available for patients who may not need urgent assessment by a respiratory specialist
 - Equity of access

Number and percentage of referrals received between July 2015 and September 2016 for publicly funded First Specialist Assessments, by health specialty and prioritisation outcome (developmental)

Source: National Patient Flow Collection, extracted on 19 April 2017.

Notes: The data presented in these tables is developmental. The Ministry advises that you should not compare numbers between DHBs as

- some DHBs are experiencing delays in their ability to submit corrected data, so there are known gaps and inconsistencies
- DHBs are working towards improvements in data quality and completeness, and the methodologies and assumptions they use to derive these measures are being refined.

In these tables, 'Number' refers to the number of referrals (not patients) in each category. The percentage for each Prioritisation Outcome category is calculated using the number of referrals for that Prioritisation Outcome category, divided by the total number of referrals received, and multiplied by 100.

More information:	Definitions for each prioritisation outcome	Data quality and limitations	Technical notes
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Health specialty	RECEIVED		ACCEPTED		DECLINED								NOT DECIDED		TRANSFERRED						
	Total received	Total accepted		Below threshold		Insufficient information		Not eligible		Service not required		Total declined		Total not decided		To another DHB		To another specialty		Total transferred	
	Number	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
July 2015																					
Anaesthesia service(s) and Pain Management	407	308	75.7%	35	8.6%	22	5.4%	22	5.4%	15	3.7%	94	23.1%	2	0.5%	1	0.2%	2	0.5%	3	0.7%
Cardiology	3,680	3,131	85.1%	62	1.7%	219	6.0%	27	0.7%	138	3.8%	446	12.1%	35	1.0%	12	0.3%	56	1.5%	68	1.8%
Cardiothoracic Surgery	149	142	95.3%	-	0.0%	-	0.0%	-	0.0%	2	1.3%	2	1.3%	-	0.0%	4	2.7%	1	0.7%	5	3.4%
Dermatology	1,614	1,341	83.1%	80	5.0%	50	3.1%	1	0.1%	73	4.5%	204	12.6%	3	0.2%	7	0.4%	59	3.7%	66	4.1%
Diabetology	675	643	95.3%	9	1.3%	1	0.1%	-	0.0%	18	2.7%	28	4.1%	-	0.0%	3	0.4%	1	0.1%	4	0.6%
Endocrinology	1,130	1,051	93.0%	12	1.1%	5	0.4%	2	0.2%	42	3.7%	61	5.4%	9	0.8%	2	0.2%	7	0.6%	9	0.8%
Gastroenterological Surgery	254	238	93.7%	-	0.0%	-	0.0%	3	1.2%	2	0.8%	5	2.0%	2	0.8%	-	0.0%	9	3.5%	9	3.5%
Gastroenterology	1,644	1,199	72.9%	113	6.9%	31	1.9%	-	0.0%	211	12.8%	355	21.6%	2	0.1%	20	1.2%	68	4.1%	88	5.4%
General Medicine	2,274	1,943	85.4%	32	1.4%	29	1.3%	5	0.2%	161	7.1%	227	10.0%	25	1.1%	9	0.4%	70	3.1%	79	3.5%
General Surgery	7,692	6,725	87.4%	388	5.0%	143	1.9%	12	0.2%	242	3.1%	785	10.2%	36	0.5%	19	0.2%	127	1.7%	146	1.9%
Gynaecology	4,323	4,044	93.5%	115	2.7%	38	0.9%	2	0.0%	92	2.1%	247	5.7%	3	0.1%	7	0.2%	22	0.5%	29	0.7%
Haematology	764	722	94.5%	2	0.3%	2	0.3%	-	0.0%	27	3.5%	31	4.1%	2	0.3%	7	0.9%	2	0.3%	9	1.2%
Immunology	240	215	89.6%	15	6.3%	-	0.0%	-	0.0%	5	2.1%	20	8.3%	-	0.0%	3	1.3%	2	0.8%	5	2.1%
Infectious Diseases	180	158	87.8%	2	1.1%	1	0.6%	-	0.0%	13	7.2%	16	8.9%	-	0.0%	6	3.3%	-	0.0%	6	3.3%
Maxillo-Facial Surgery	164	152	92.7%	4	2.4%	-	0.0%	-	0.0%	4	2.4%	8	4.9%	-	0.0%	2	1.2%	2	1.2%	4	2.4%
Neurology	1,969	1,704	86.5%	80	4.1%	16	0.8%	5	0.3%	79	4.0%	180	9.1%	7	0.4%	56	2.8%	22	1.1%	78	4.0%
Neurosurgery	429	399	93.0%	2	0.5%	-	0.0%	-	0.0%	6	1.4%	8	1.9%	1	0.2%	20	4.7%	1	0.2%	21	4.9%
Oncology	2,046	1,972	96.4%	25	1.2%	14	0.7%	1	0.0%	4	0.2%	44	2.2%	-	0.0%	13	0.6%	17	0.8%	30	1.5%
Ophthalmology	5,487	4,898	89.3%	291	5.3%	29	0.5%	27	0.5%	158	2.9%	505	9.2%	13	0.2%	48	0.9%	23	0.4%	71	1.3%
Orthopaedic Surgery	8,195	6,862	83.7%	758	9.2%	251	3.1%	17	0.2%	186	2.3%	1,212	14.8%	16	0.2%	78	1.0%	27	0.3%	105	1.3%
Other Medical Services	10	9	90.0%	1	10.0%	-	0.0%	-	0.0%	-	0.0%	1	10.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Otorhinolaryngology (ENT)	5,351	4,442	83.0%	519	9.7%	145	2.7%	10	0.2%	167	3.1%	841	15.7%	18	0.3%	28	0.5%	22	0.4%	50	0.9%
Paediatric Medicine	3,144	2,818	89.6%	42	1.3%	24	0.8%	3	0.1%	155	4.9%	224	7.1%	1	0.0%	20	0.6%	81	2.6%	101	3.2%
Plastic Surgery (excluding burns)	1,663	1,476	88.8%	85	5.1%	43	2.6%	11	0.7%	25	1.5%	164	9.9%	1	0.1%	15	0.9%	7	0.4%	22	1.3%
Radiotherapy	195	194	99.5%	-	0.0%	-	0.0%	-	0.0%	1	0.5%	1	0.5%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Renal Medicine	522	465	89.1%	19	3.6%	9	1.7%	-	0.0%	19	3.6%	47	9.0%	1	0.2%	7	1.3%	2	0.4%	9	1.7%
Respiratory Medicine	1,901	1,688	88.8%	60	3.2%	40	2.1%	3	0.2%	53	2.8%	156	8.2%	25	1.3%	20	1.1%	12	0.6%	32	1.7%
Rheumatology	1,000	890	89.0%	36	3.6%	4	0.4%	11	1.1%	41	4.1%	92	9.2%	1	0.1%	3	0.3%	14	1.4%	17	1.7%
Specialist Paediatric Cardiology	98	93	94.9%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	4	4.1%	1	1.0%	5	5.1%
Specialist Paediatric Diabetology	1	1	100.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%

What do I want to know?

- What is the clinical question?
- What is the expectation of the referral?
 - Clinic review?
 - Written advice?
 - Arranging imaging?
- Are there any red flags?
- What has been done so far?
- What is the patient's smoking status?
 - Current/ former (when stopped?)/ never
 - Estimate of pack year history

46 year old Maori Female

Request Clinic assessment

Semi-urgent

Review and assessment breathing troubles

Clinical notes

Dear Team

Thanks for seeing who is reported to have significant COPD but seems also to be even more short of breath than one might expect. She was in hospital recently and it was wondered whether anxiousness was also playing a part in the feelings of SOB. She is on asthma treatment and also takes antihistamines. I have offered her Clonazepam drops for fretfulness in the hope it might prove to be helpful for feelings of respiratory distress. It was also recommended she, especially as she is so young, be referred for formal work up regarding her breathing troubles.

Thanks

Problems

Trying to give up smoking

Current smoker

Alcohol intake within rec limit

Current smoker

6-7 per day

Current smoker

10-15/pd

Smoking cess behaviour support

NBPH

Ex smoker

NBPH

Current smoker

NBPH

Prescribed smoking cess med

NBPH

Chronic obstructive pulm.dis.

severe on spirometry 2012 Sept, w significant reversibility

Asthma

Current smoker

NBPH

FH: Family history

mother died lymphoma 49,g mother diabetes

H/O: meningitis

as infant

51 year old Pakeha Female

Request	Clinic assessment Routine Presented early Dec with persisting cough Responded to antibiotics and prednisone However subsequent X ray showed a nodule and this was replicated on a repeat X ray-different view Needs a CT to
Clinical notes	exclude underlying problem Is generally well Has controlled epilepsy. 06-Dec-2016 10:15 Paroxysmal cough continues. Has been using inhalers (and PF has improved from 180 to 320) Chest clinically clear. For course amoxil and prenisone Chest X ray Review 2/52 if not better.
Problems	Vaginal hysterectomy 2003 Current non drinker Epilepsy juvenile myoclonic epilepsy Open bilat ligat fallop tubes april 94 Allergic rhinitis

66 year old Pakeha Male

Request	Written advice only	
	Routine	
	asbestos exposure	
Clinical notes	Dear Colleague ,	
	thankyou for advice regarding	
	He used to work for NIWA until 5 years ago . They have contacted him to let him know asbestos has been found in he dust in a warehouse where he worked for 15 yearsr prior to finishing with NIWA .	
	He has long reported what he feels is undue SOBOE for which no specific cause has been found . He had normal spirometry and ETT in 2012 . A CXR done for cough in march 16 is normal . this cough has largely settled after chaning his ACEI .	
Problems	What do you suggest in terms of surveillance / management from here .	
	Congenital anomalies	R ear
	Obesity	
	[D]Prediabetes	
	Alcohol consumption	2 glasses/week
	Prostatism	FHx ca prostate
	[D]Snoring	Ts and UPPP
	Allergic rhinitis	
	Hyperlipidaemia NOS	8.1 -2005
	Never smoked tobacco	
	Essential hypertension	

Triaging by Condition

Triage Category	Expected Timeframe	Examples
Triage 1	Acute admission	- Acute Symptomatic Pneumothorax - Massive Haemoptysis
Triage 2	Within 7 days	Symptomatic Pleural Effusion
High Suspicion of Lung Cancer	Within 14 days	- Chest X-ray or other imaging suggestive/ suspicious of lung cancer - Persistent or unexplained haemoptysis in high risk individuals over 40 years of age
Triage 3	Within 28 days	- Respiratory failure for consideration of domiciliary oxygen - Interstitial lung disease – if symptomatic / high risk - Unstable asthma
Triage 4	Within 120 days	- Bronchiectasis - COPD (see HealthPathways for COPD referral criteria) - Chronic cough not responding in spite of HealthPathways - Unexplained dyspnoea (see HealthPathways)
Virtual FSA	-	Nodule Surveillance

What Resources are Available to You?

- Health Pathways
 - Southern
 - Canterbury
 - 3D
 - Auckland Regional
- Map of Medicine
 - Midland DHBs
 - MidCentral


Search

- + Cardiology
- + Dermatology
- + Diabetes
- + Endocrinology
- + Gastroenterology
- + General Medicine
- + Genetics
- + Haematology
- + Hyperbaric Medicine
- + Immunology
- + Infectious Diseases
- + Intellectual Disability
- + Nephrology
- + Neurology
- + Oncology
- + Pain Management
- + Palliative Care
- Respiratory
 - + Asthma in Adults
 - Bronchiectasis
 - Chronic Cough in Adults
 - + Community Acquired Pneumonia (CAP) i
 - + COPD
 - Dyspnoea
 - Haemoptysis
 - Home Oxygen
 - Legionnaires' Disease
 - Tuberculosis
 - Respiratory Requests
 - Acute Respiratory Assessment
 - **Non-acute Respiratory Assessment**
 - Respiratory Specialised Advice
 - Cardio-Respiratory Integrated Special
 - + Community Respiratory Services
- + Rheumatology
- + Sexual Health
- + Sleep
- + Spinal Cord Impairment (SCI)
- + Medicolegal
- + Mental Health
- + Older Adults Health
- + Pharmacology
- + Public Health
- + Specific Populations
- + Surgical
- + Women's Health
- + Our Health System

Christchurch Hospital Respiratory Department

The central triage point for all publicly funded respiratory referrals, including Ashburton and surrounding areas.

1. Check criteria:

- - [Seen within 4 months.](#)

Within 7 days

- Possible lung cancer
- Possible tuberculosis
- Unexplained unilateral pleural effusions, query malignant
- Haemoptysis with abnormal chest X-ray

Within 4 weeks

- Respiratory failure for consideration of [home oxygen](#) (if criteria fulfilled)
- Interstitial lung disease - provide details of degree of breathlessness, plus time course if known
- [Haemoptysis](#) with normal chest X-ray but with risk factors for malignancy or tuberculosis – consider arranging community CT chest with respiratory request.
- Unstable or brittle asthma e.g., multiple admissions or ICU

Within 4 months

- Unexplained [breathlessness](#)
- [Haemoptysis](#) with normal chest X-ray without risk factors for malignancy or tuberculosis
- [Bronchiectasis](#), if criteria are met
- The following, if failure to respond to treatment according to pathway:
 - Poorly controlled [asthma](#)
 - [Chronic cough](#)
 - [COPD](#)
- Interstitial lung disease if long standing, or not symptomatic
- Atypical chest pain suggestive of respiratory cause with normal chest X-ray
- Recurrent chest infections with normal chest X-ray or CT

• Not seen:

- + [Alternative pathway recommended](#)
- + [General practice or community management](#)

2. Include + [triage information for respiratory assessment](#).

3. If + [criteria for high suspicion of lung cancer](#) are met, select ERMS priority high suspicion of cancer, or write "high suspicion of cancer" on the request. Consider referring to Cancer Support Services.

[Acute Respiratory Assessment](#)
[Respiratory Advice](#)

Search

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Respiratory

In This Section

[Asthma in Adults](#)[Bronchiectasis](#)[Chronic Cough in Adults](#)[Community Acquired Pneumonia \(CAP\) in Adults](#)[COPD](#)[Dyspnoea](#)[Haemoptysis](#)[Home Oxygen](#)[Legionnaires' Disease](#)[Tuberculosis](#)[Respiratory Requests](#)

See Also

[Asbestos Exposure](#)[Legionnaires' Disease](#)[Smoking Cessation Advice](#)[Spirometry Interpretation](#)

Page Information

Information about this HealthPathways document (11932):

Document Owner: Respiratory Team (see [Who's Who](#))

Last Updated:

Next Review:

Keywords:

Note: Only the electronic version is controlled. Once printed, this is no longer a controlled document.

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- + Child and Youth Health
- + Investigations
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Chronic Cough in Adults

This pathway is for adults who present with a **persistent cough > 8 weeks** duration.

For children, see [Chronic Cough In Children](#).



Red Flags

-  [Haemoptysis](#)
-  [Suspected malignancy or tuberculosis](#)
-  [Voice change](#) in smokers or ex-smokers

Assessment

1. Take history of cough. Consider:
 - onset, triggers, work environment, upper airway symptoms, aspiration, reflux.
 - ACE-inhibitor or other medications.
 - smoking status.
 - snoring and sleep apnoea (these cause airway drying and increased reflux).
2. Explore previous cough treatments and if there is evidence of:
 - insufficient dose or duration
 - inadequate technique
 - poor compliance.
3. Consider common differentials:
 - + [Asthma](#)
 - + [Gastro-oesophageal reflux](#)
 - + [Rhinosinusitis](#)
 - Post-infectious cough is often aggravated or prolonged by any of the 3 conditions above.
 - + [ACE inhibitors](#)
 - Snoring and [sleep apnoea](#).
4. Investigations:
 - [Chest X-ray](#).
 - [Spirometry](#) and bronchodilator reversibility.
 -  [Sputum culture](#) for productive cough.
 - Arrange mycobacterial culture for tuberculosis if chest X-ray is suggestive.

Note: Occasionally fungi such as *Aspergillus* may be isolated from sputum culture. It occurs more commonly after recent antibiotics and may not be significant. Repeat sputum test after 1 month.

Related Topics

[Dyspepsia and Heartburn / GORD](#)
[Asthma in Adults](#)
[Rhinosinusitis](#)

Management



Practice Point!

It is important to emphasise that treatments often take a number of months to be effective.

Productive cough

1. Manage any primary lung pathology such as [smoking-related chronic bronchitis](#) (smoker's cough), [COPD](#), [bronchiectasis](#), or [tuberculosis](#).
2. Consider and treat [rhinosinusitis](#), and [+ microaspiration](#) from tooth and gum disease.

Non-productive or minimally productive cough

1. Eliminate any aggravating factors if possible.
 - If the patient is on ACE-inhibitor, consider an alternative. ACE-related cough can take 3 months to resolve.
 - Offer [smoking cessation advice](#).
2. Aim treatment at suspected underlying cause:
 - [+ Asthma](#) or [COPD](#)
 - [+ Rhinosinusitis](#)
 - [+ Gastro-oesophageal reflux](#)
 - Snoring and [sleep apnoea](#).
3. Over-the-counter cough medicines are rarely effective.

Request

- If X-ray is inconclusive or there is uncertainty, seek [respiratory advice](#).
- Request [respiratory assessment](#) if:
 - [haemoptysis](#). If significant, seek [respiratory advice](#).
 - suspected malignancy or [tuberculosis](#).
- If voice change in smokers or ex-smokers, request [ORL assessment](#).
- If failed or inadequate response, request [respiratory assessment](#). Include in all requests full details of treatments trialled, including dose and duration.
- If [criteria for high suspicion of lung cancer](#) are met, select ERMS priority [high suspicion of cancer](#), or write "high suspicion of cancer" on the request. Consider referring to [Cancer Support Services](#).

Information

[+ Clinical Resources](#)[+ Patient Information](#)

- + Child and Youth Health
- + Investigations
- + Lifestyle
- Medical
 - + Assault or Abuse
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 - + Dermatology
 - + Diabetes
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What About Lung Cancer?



Lung cancer continues to be one of the most common cancers worldwide, claiming more lives yearly than breast, colon, and prostate cancers combined.

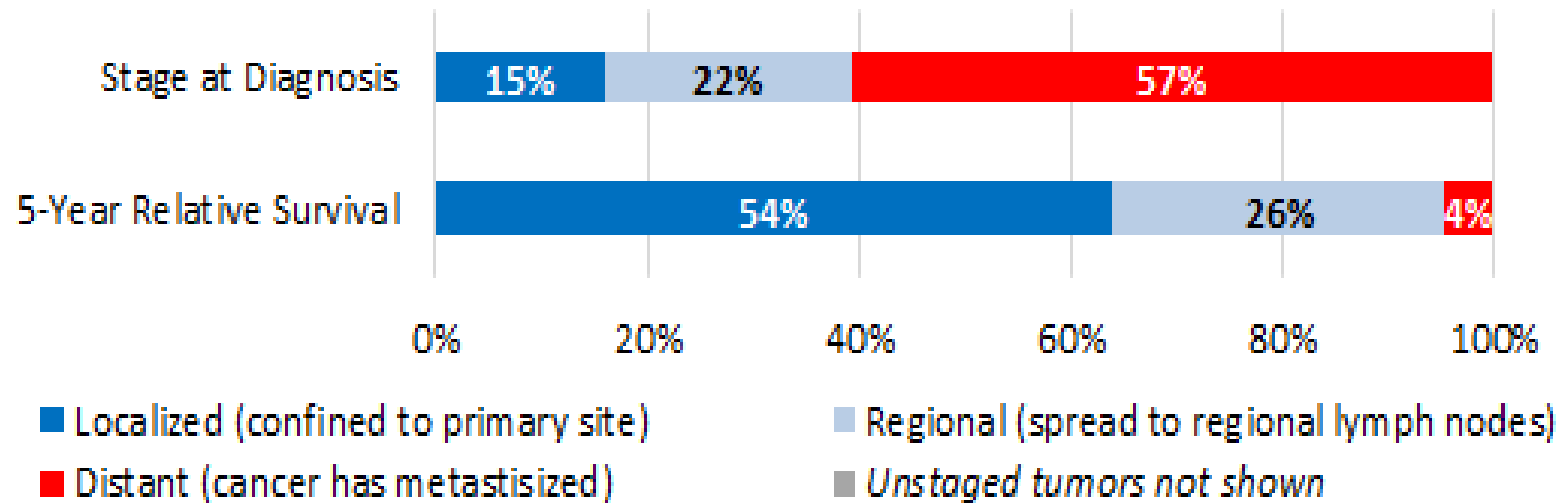
#WorldLungCancerDay

Overview

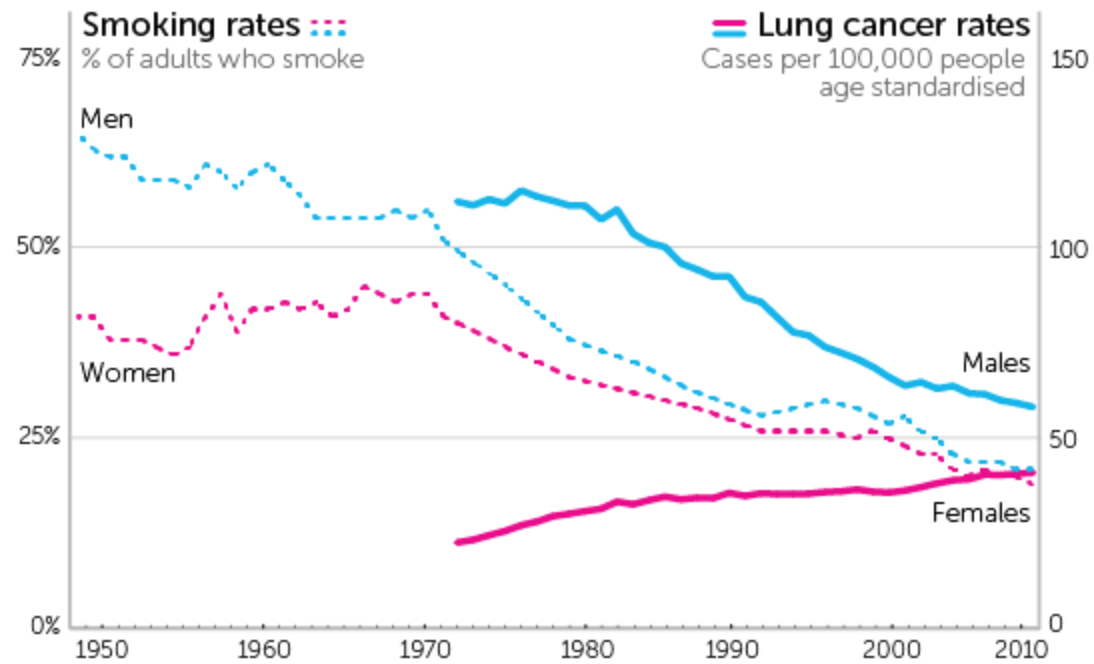
- Lung Cancer is the leading cause of cancer related death
- Cure is possible for patients with early stage disease but majority of patients have advanced disease at time of diagnosis
 - Aims of treatment are quality of life, palliation of symptoms and prolonged survival
- Major risk factor is smoking
 - Incidence of non-smoking related lung cancers is increasing

Stage and Prognosis

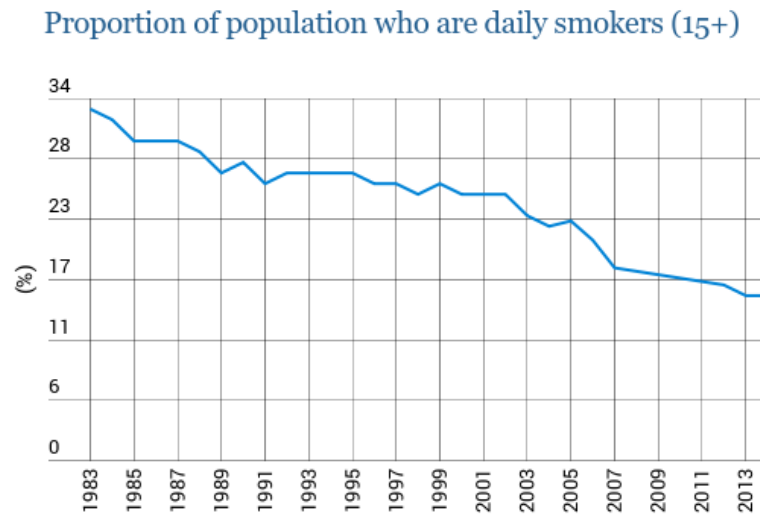
Lung Cancer Diagnosis and Survival By Stage, 2003-2009⁴



SMOKING RATES AND LUNG CANCER RATES IN THE UK

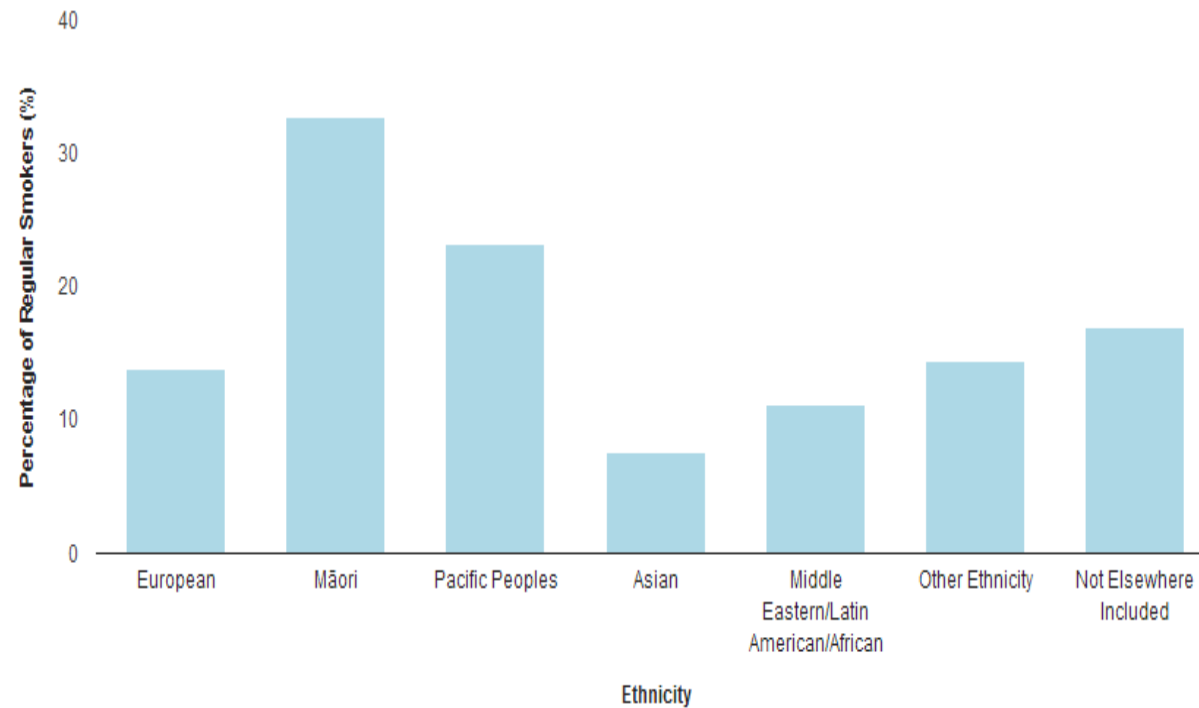


NZ smoking prevalence



Source: OECD

NZ smoking prevalence



While smoking cigarettes remains the main risk factor for lung cancer, 10% of men and 20% of women with lung cancer have never smoked.

CHEST Foundation

What Are the Red Flags?

- Unexplained/persistent (≥ 3 weeks)
 - haemoptysis
 - cough
 - shortness of breath
 - chest/shoulder pain
 - weight loss greater than 10%
 - hoarseness
- Finger clubbing
- Cervical and/or persistent supraclavicular lymphadenopathy
- Chest X-ray or other imaging suspicious of lung cancer

*High risk factors

When making a decision to refer, assess and document risk factors for lung cancer. These include:

- smokers or ex-smokers
- history of exposure to asbestos,
- pre-existing lung disease particularly COPD or interstitial lung disease
- history of cancer

It should be noted the incidence of non-smoking related cancer is increasing particularly in women and East Asians.

Clinical Presentation

Symptom	Primary Care Presentation (206)				Secondary Care Presentation of ALL cases (272)			
	Frequency N %		% with symptoms for ≤ 1mth 1-2mth		Frequency N %		% with symptoms for ≤ 1mth 1-2mth	
Haemoptysis	30	15	73†	3	52	19	44	18
			Unstated	20%			Unstated	36%
Cough	101	49	48	5	134	49	24	13
			Unstated	30%			Unstated	19%
Shortness of breath	36	17	44	3	102	38	25	7
			Unstated	42%			Unstated	52%
Pneumonia	5	2	-		28	10	-	
Chest pain	45	22	51	7	76	28	27	8
			Unstated	36%			Unstated	51%
Wheeze	10	5	30	20	11	4	28	0
			Unstated	40%			Unstated	64%
Dysphagia	5	2	80	20	8	3	38	13
			Unstated	0%			Unstated	50%
Hoarseness	7	3	43	0	11	4	54	0
			Unstated	57%			Unstated	27%
Palpable Lymph Node	4	2	-		3	1	-	
Superior Vena Cava Obstruction (SVCO)	-	-	-		5	2	-	
Weight Loss	26	13	15	4	83	31	15	13
			Unstated	50%			Unstated	0%
Fever	9	4	-		23	9	-	
Fatigue	16	8	-		35	13	-	
Non-specific	27	13	-		42	15	-	
Metastatic symptoms eg neurological symptoms; abdominal pain; mass etc	21	10	45	0	34	13	47	9
			Unstated	50%			Unstated	30%

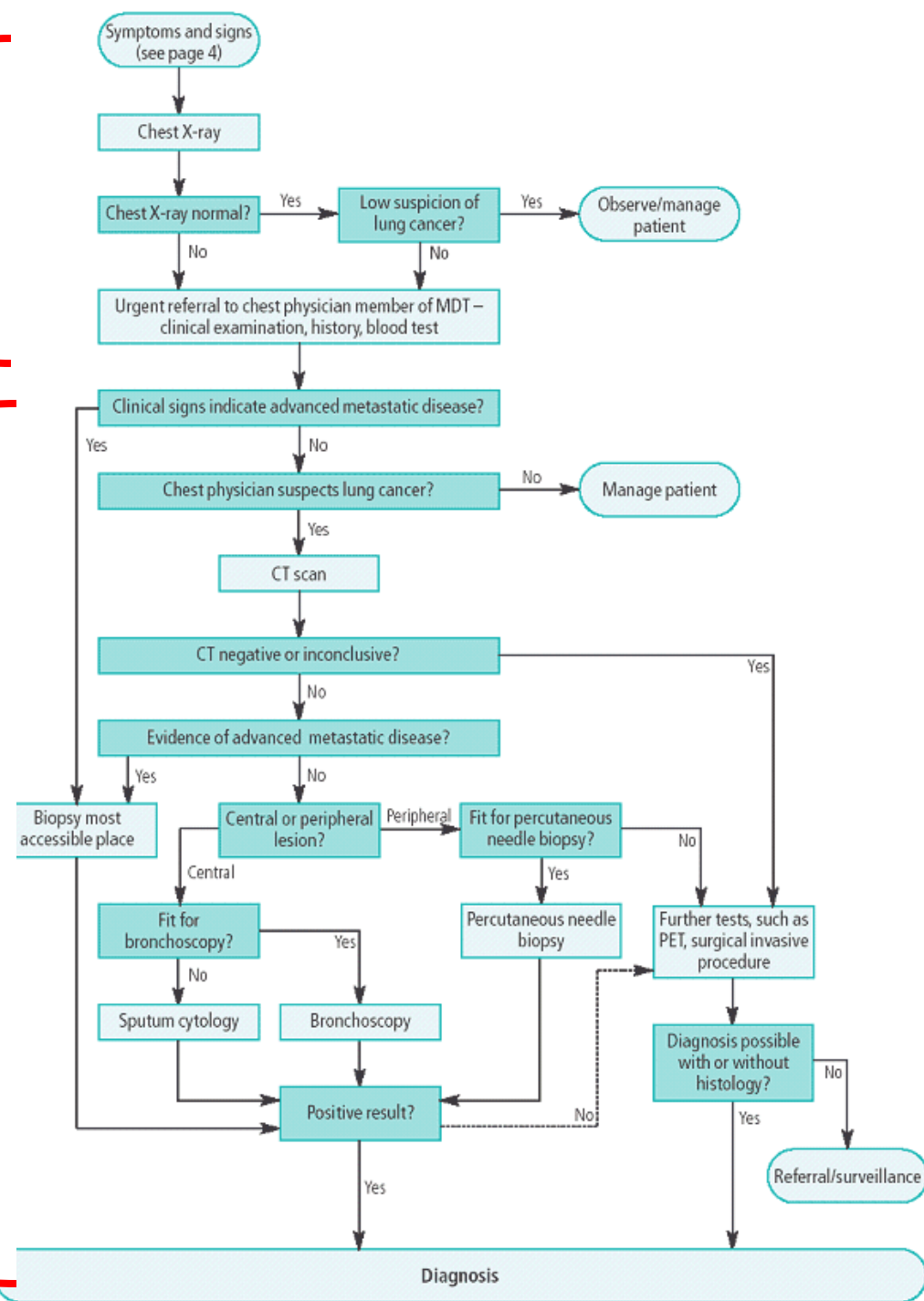
† 40% of cases with haemoptysis had it for less than 1 week when they presented to primary care.

67 year old Pakeha Male

Request	Clinic assessment Semi-urgent Atypical lesion right upper lung ---for CT scan	
Clinical notes	This man has been a heavy smoker for most of his life and has really only tried to stop in the last year. He is currently using habitrol patches. He is very lean and over the last 2 years has had an unexplained weight loss of 6 kgs making him now 58kgs. Because of this I arranged a Chest x ray and this has shown a right upper zone band-like opacity that was not present in 2014. A Respiratory opinion/CT scan has been recommended to follow this up and I would be grateful if this could be implemented. He is being treated for hypertension and has musculoskeletal problems but is otherwise well . Thank you.	
Problems	Trying to give up smoking	1 Sept 2014
	Current smoker	1 Sept 2014
	Ex smoker	1 Sept 2014
	Un-Classified Problem	Osteoarthritis left knee
	Hypertensive disease	
	Benign prostatic hypertrophy	
	Cervical spinal stenosis	
	Chronic obstructive pulm.dis.	
	Un-Classified Problem	L4/5 laminectomy and discectomy in Dunedin 1994 acutely with neurological symptoms.
	Pain in lumbar spine	
	Osteoarthritis	

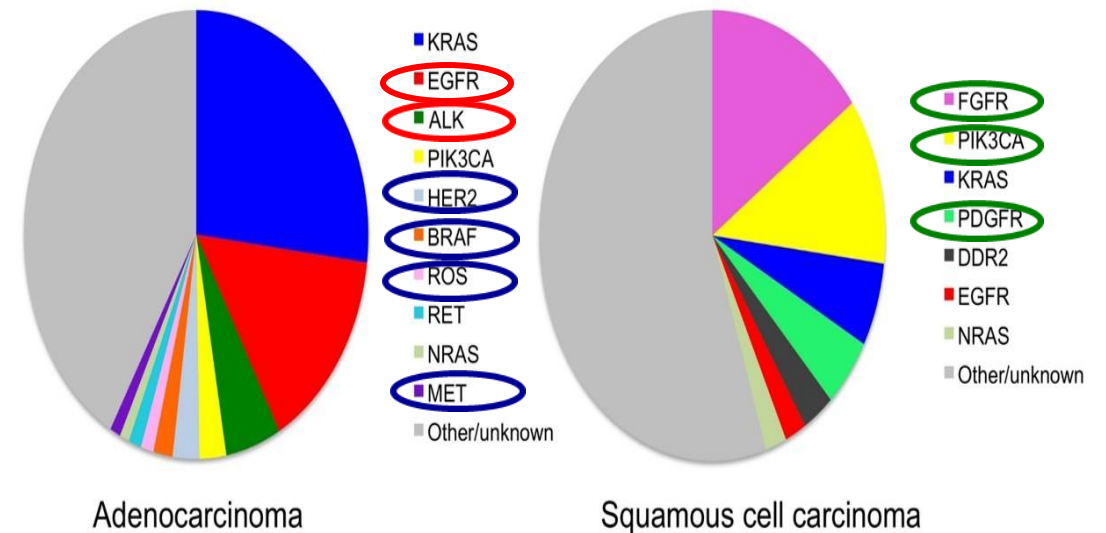
General Practice

Respiratory Clinic



Advances in Lung Cancer

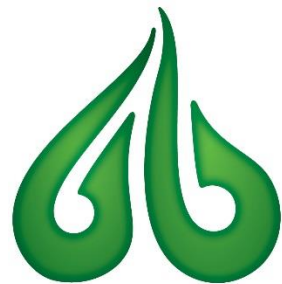
- CT Screening
 - Improves survival in high risk population
- Improved accuracy in diagnosis and staging
- Targeted therapies in advanced lung cancer
 - Prolongs survival in populations with specific molecular profiles



Take Home Points

- Respiratory Conditions are a common cause of presentation to Health Care Providers
- A collaborative approach between primary and secondary care improves management of our patients
 - Think about becoming involved as a GP liaison
- Think about lung cancer in patients with persisting respiratory symptoms
- Don't discount lung cancer if your patient has not been a smoker

Thank You



TUAPAPA PŪKAHUKAHU
LUNG FOUNDATION
New Zealand
