The Royal Melbourne Hospital

phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

National Lung Cancer Screening Program – What's involved and how do I prepare?

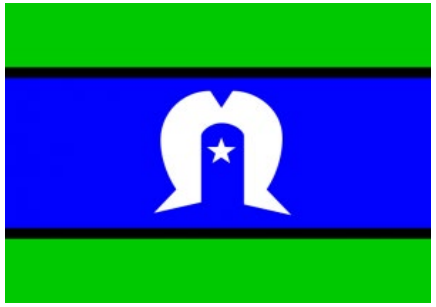
Tuesday 25 February 2025

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



Housekeeping – Zoom Meeting

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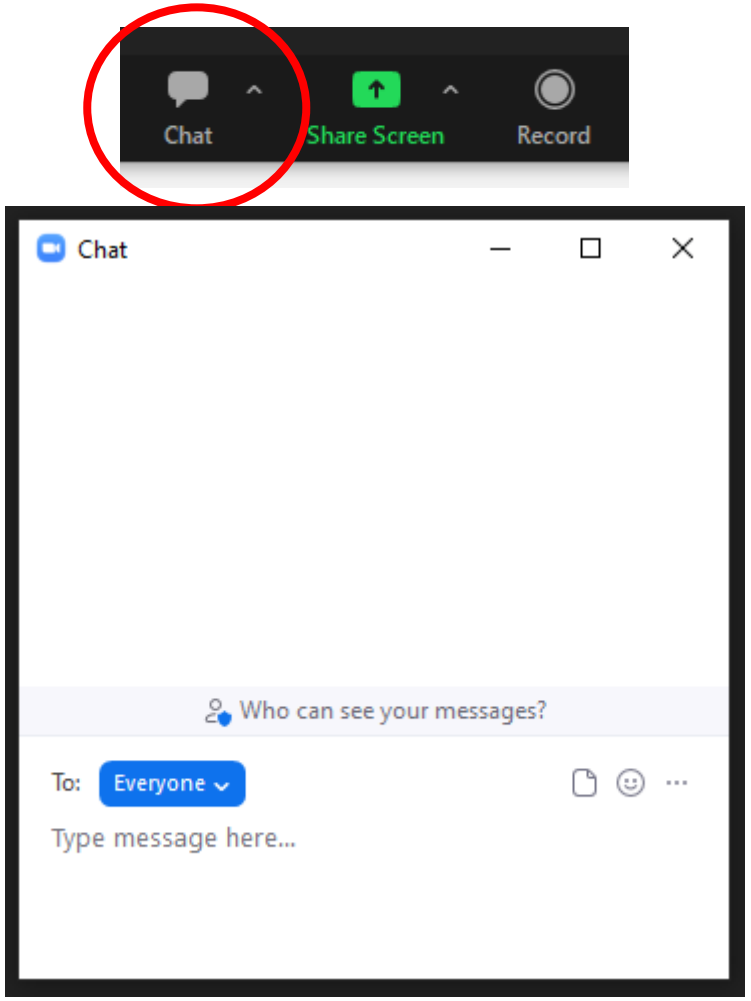
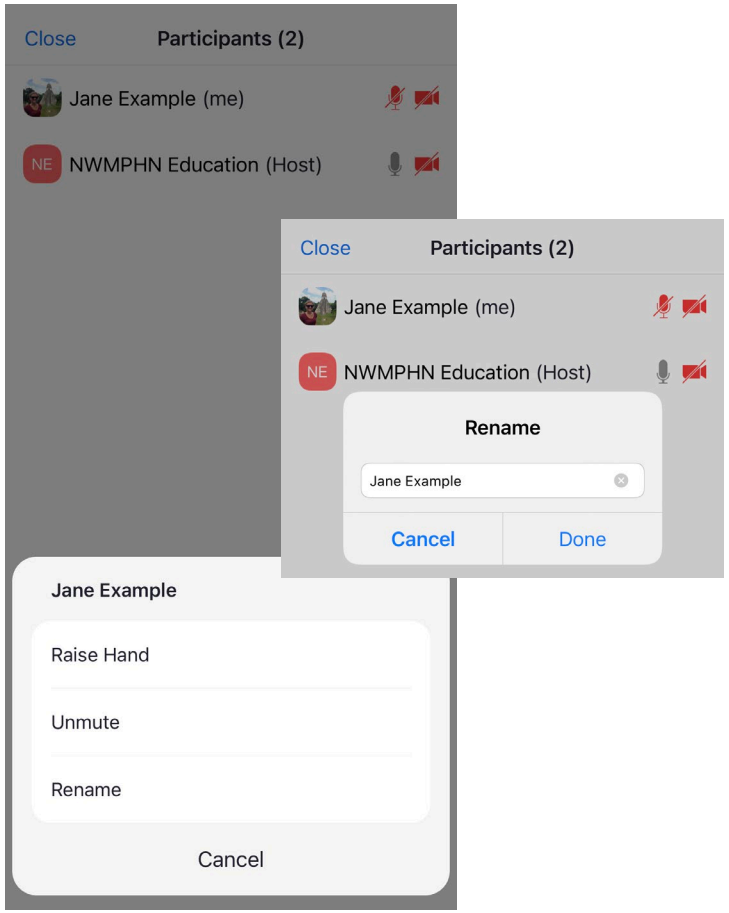
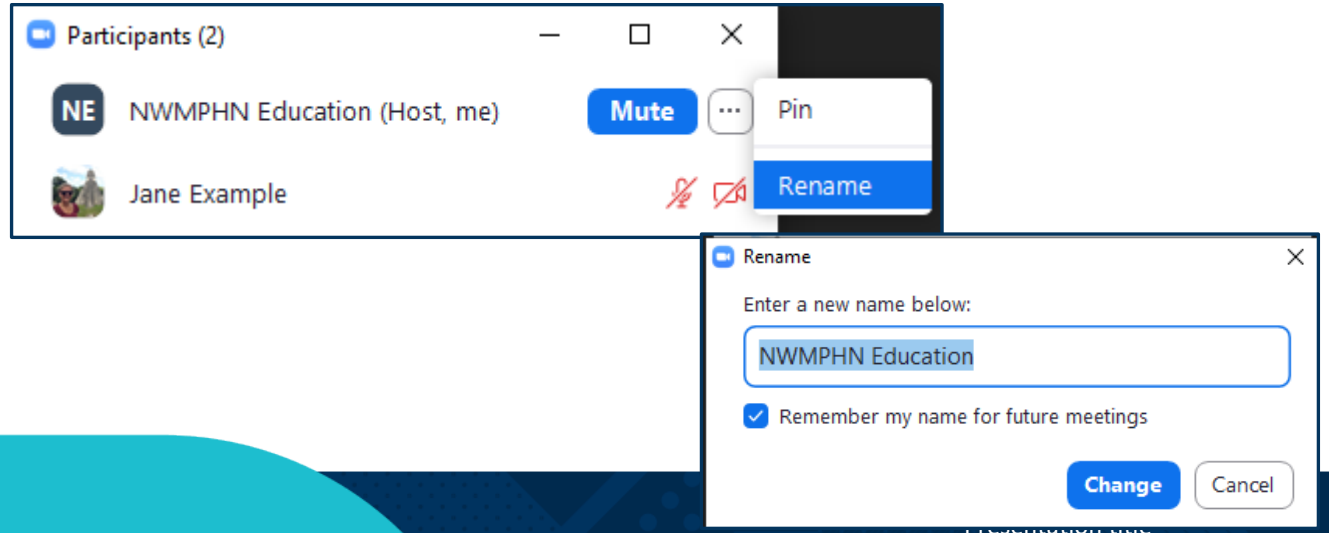


How to change your name in Zoom Meeting

1. Click on ***Participants***
2. **App:** click on your name
   Desktop: hover over your name and click the 3 dots
   Mac: hover over your name and click *More*
3. Click on ***Rename***
4. Enter the name you registered with and click
   Done / Change / Rename





Agenda

Time	Topic
6:30pm-6:35pm	Welcome & Housekeeping
6:35pm-6:40pm	Poll questions
6:40pm-6:55pm	Information about the National Lung Cancer Screening program
6:55pm-7:05pm	How practices can use CAT4 to identify patients by age and smoking status in line with the eligibility criteria
7:05pm-7:25pm	Localised services/pathways and information relevant to the north western Melbourne catchment
7:25pm-7:35pm	HealthPathways Melbourne presentation
7:35pm-7:40pm	Poll questions
7:40pm-8:00pm	Q&A & Wrap-up

Speaker

Dr Asha Bonney, Royal Melbourne Hospital

Dr Asha Bonney is a respiratory and sleep physician at the Royal Melbourne Hospital. Her other roles include lecturer at the University of Melbourne, respiratory and sleep physician at Eastern Health, and member of the Thoracic Society of Australia and New Zealand Lung Cancer Working Party. She recently completed a PhD in the field of lung cancer screening and is the clinical lead of the Lung Nodule Clinic at RMH and lead of the Lung Nodule and Screening Program at RMH.

Pre-Presentation Poll Questions

1

Information about the National Lung Cancer Screening program

Dr Asha Bonney – RMH

National Lung Cancer Screening Program

Dr Asha Bonney

North Western Melbourne Primary Healthcare Network Series 1

25/02/2025

The Royal Melbourne Hospital

Lung cancer in Australia.

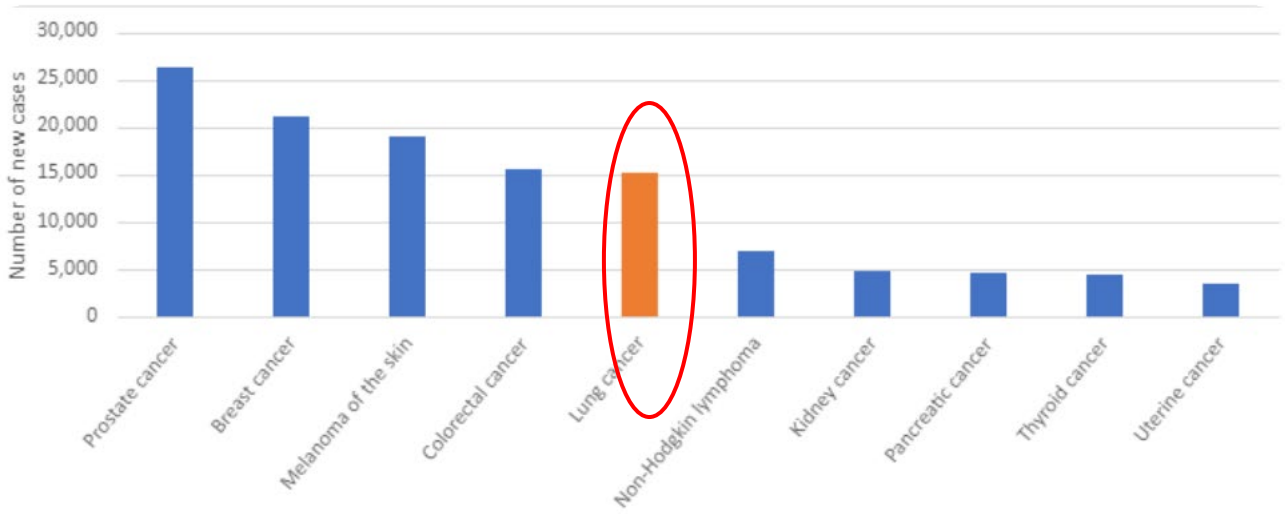


Figure 1. Estimated cancer incidence in Australia, 2024

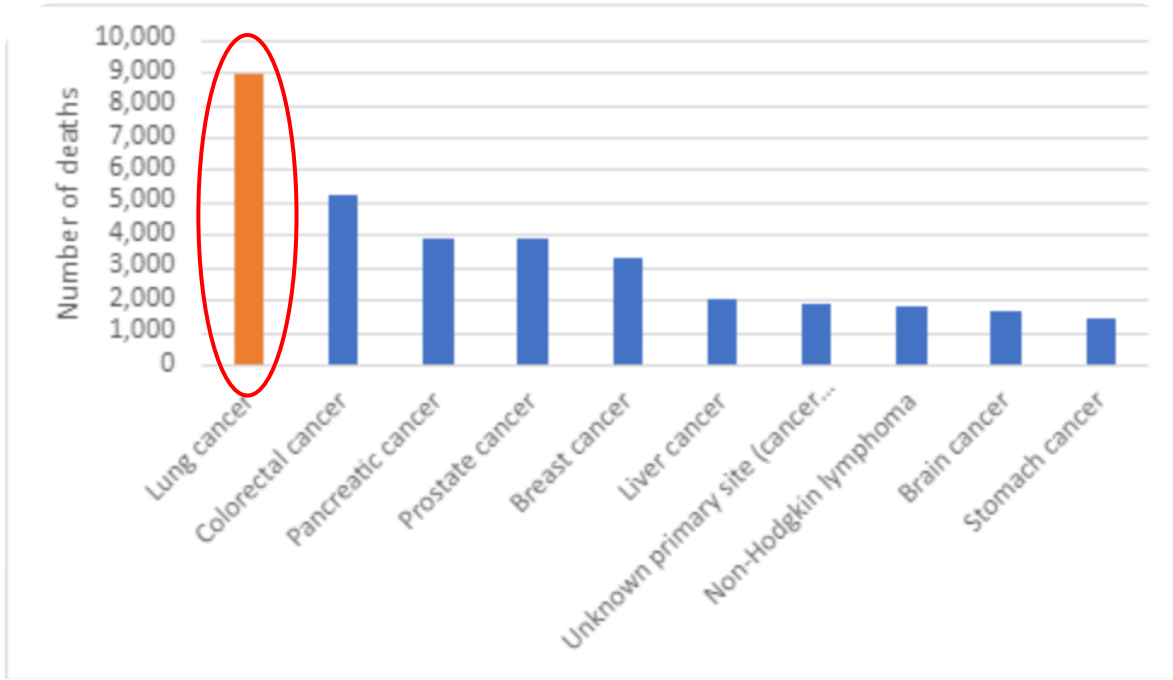
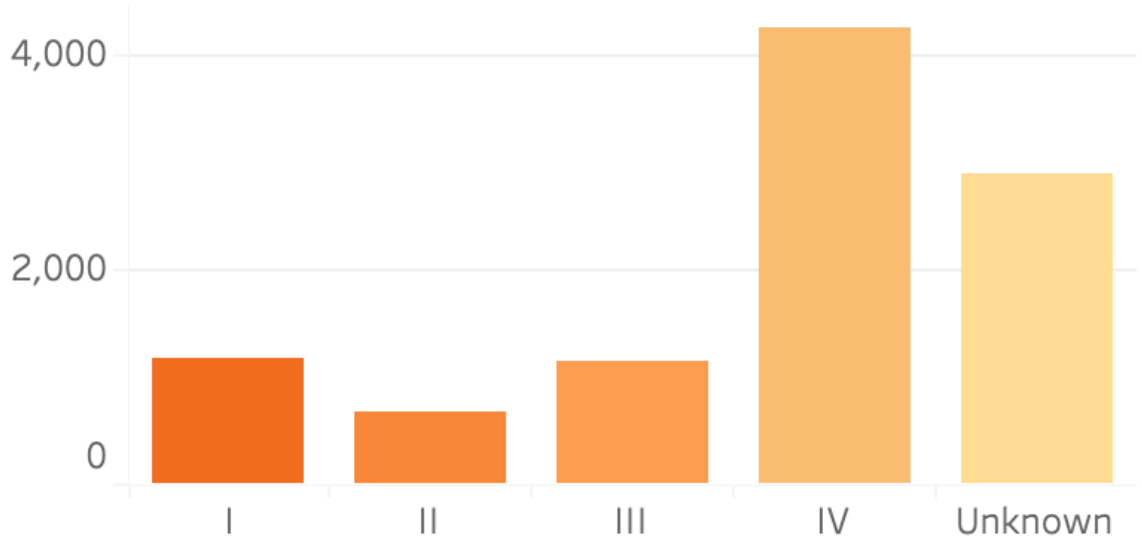


Figure 3. Estimated cancer mortality in Australia, 2024

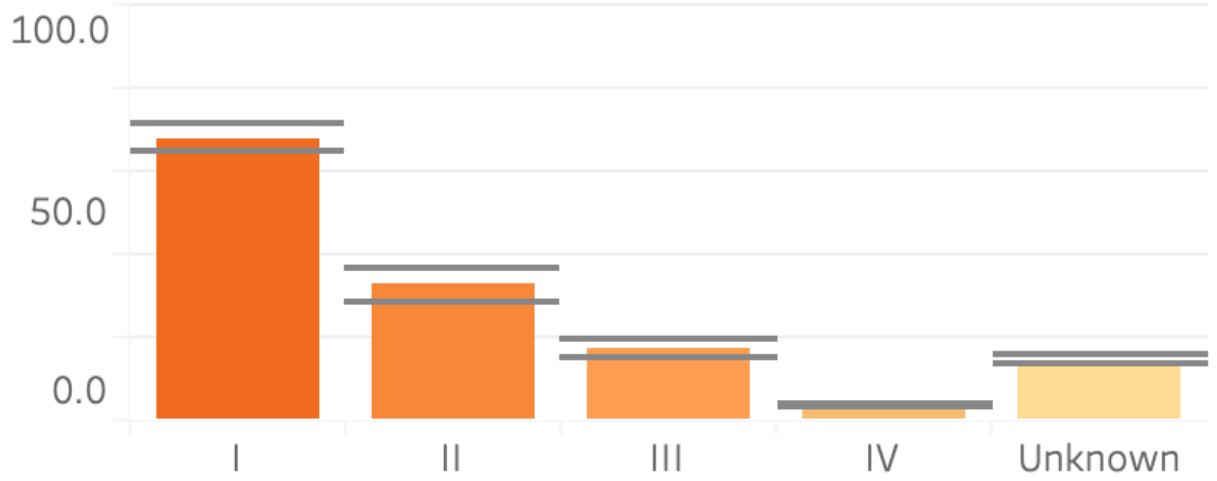
Australian Government
Cancer Australia

Why screen?

Number of cases, by stage at diagnosis
Lung cancer, Persons

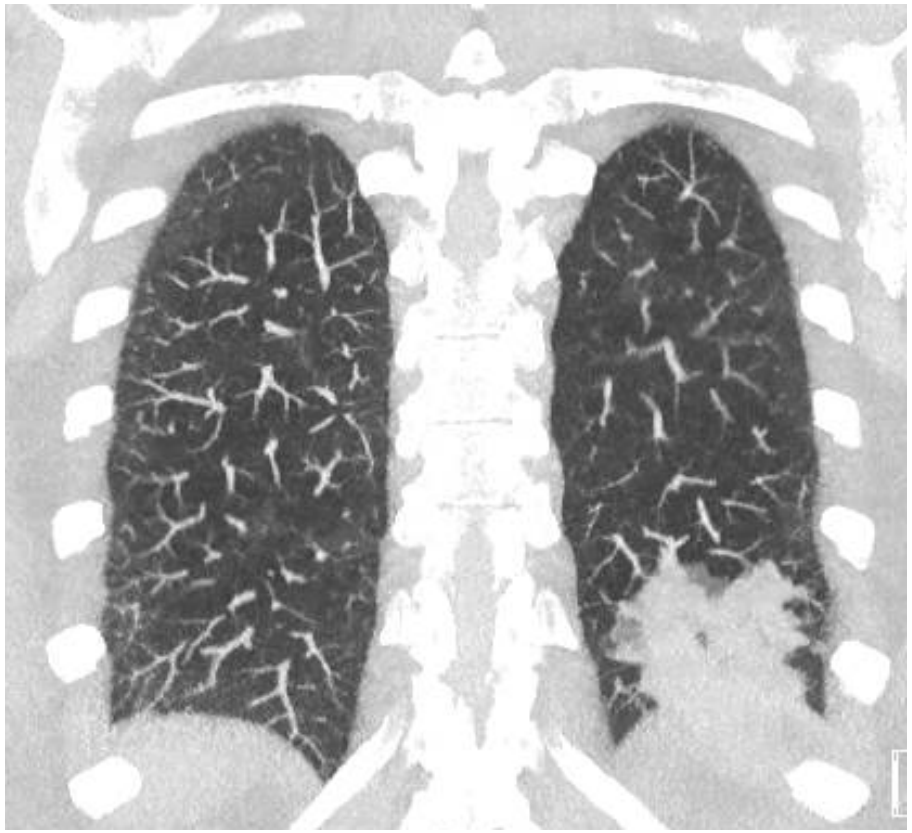


5-year relative-survival, by stage at diagnosis
Lung cancer, Persons



Australian Government
Australian Institute of Health and Welfare

Lung cancer detection

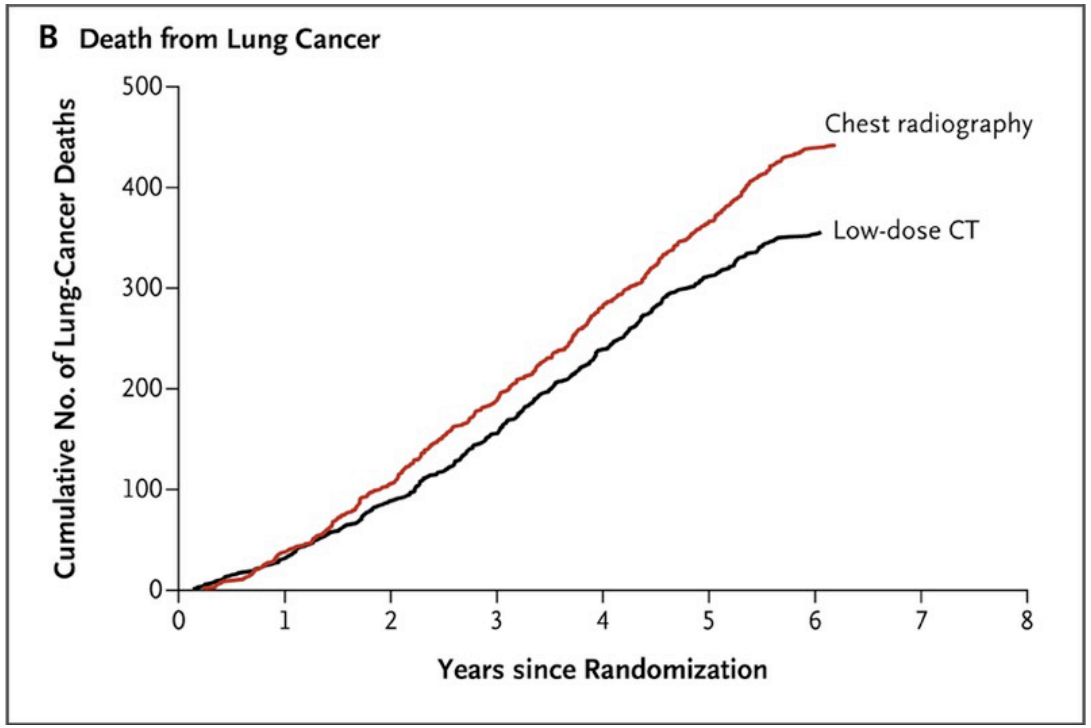


The NEW ENGLAND JOURNAL of MEDICINE

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*

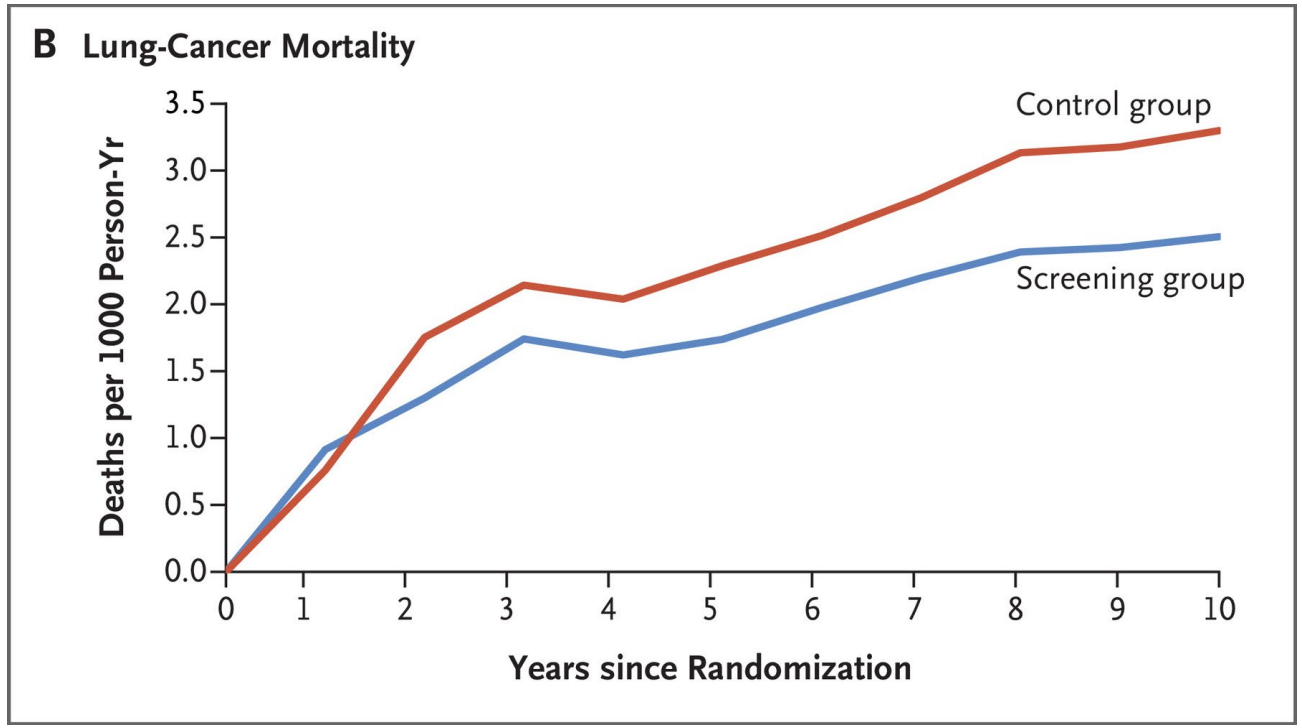


The NEW ENGLAND JOURNAL of MEDICINE

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



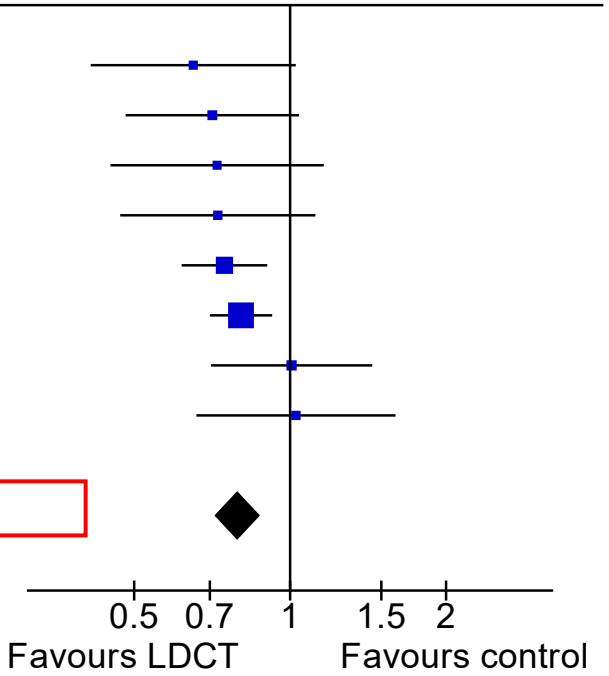
Lung cancer-related mortality

Study or Subgroup	LDCT Events	LDCT Total	Control Events	Control Total	Weight	Risk Ratio M-H, Random, 95% CI
Field 2021	30	1987	46	1981	4.2%	0.65 [0.41 , 1.03]
Paci 2017	43	1613	60	1593	5.9%	0.71 [0.48 , 1.04]
Becker 2020	29	2029	40	2023	3.9%	0.72 [0.45 , 1.16]
Pastorino 2012	40	2376	40	1723	4.7%	0.73 [0.47 , 1.12]
De Koning 2020	181	7900	242	7889	24.3%	0.75 [0.62 , 0.90]
Aberle 2011	356	26722	443	26732	45.7%	0.80 [0.70 , 0.92]
Infante 2015	59	1264	55	1186	6.8%	1.01 [0.70 , 1.44]
Wille 2016	39	2052	38	2052	4.5%	1.03 [0.66 , 1.60]
Total (95% CI)		**45943**		**45179**	**100.0%**	**0.79 [0.72 , 0.87]**
Total events:	777		964			

Heterogeneity: Tau² = 0.00; Chi² = 4.79, df = 7 (P = 0.69); I² = 0%

Test for overall effect: Z = 4.92 (P < 0.00001)

Test for subgroup differences: Not applicable



Cochrane Library

Cochrane Database of Systematic Reviews

All-cause mortality

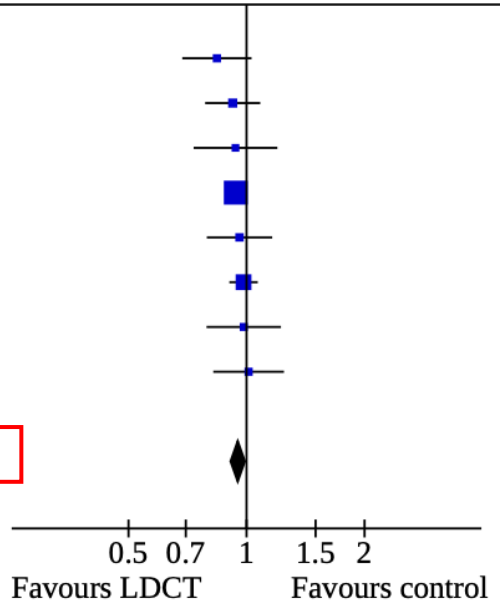
Analysis 3.1. Comparison 3: Secondary outcome: all-cause mortality, Outcome 1: All-cause mortality - planned time points (latest time points)

Study or Subgroup	LDCT Events	LDCT Total	Control Events	Control Total	Weight	Risk Ratio M-H, Random, 95% CI
Paci 2017	154	1613	181	1593	4.3%	0.84 [0.69 , 1.03]
Field 2021	246	1987	266	1981	6.8%	0.92 [0.78 , 1.08]
Pastorino 2012	137	2376	106	1723	2.9%	0.94 [0.73 , 1.20]
Aberle 2011	1877	26722	2000	26732	48.1%	0.94 [0.88 , 1.00]
Infante 2015	180	1264	176	1186	4.8%	0.96 [0.79 , 1.16]
De Koning 2020	959	7895	974	7879	25.4%	0.98 [0.90 , 1.07]
Becker 2020	148	2029	150	2023	3.7%	0.98 [0.79 , 1.22]
Wille 2016	165	2052	163	2052	4.1%	1.01 [0.82 , 1.25]
Total (95% CI)		**45938**		**45169**	**100.0%**	**0.95 [0.91 , 0.99]**
Total events:	3866		4016			

Heterogeneity: Tau² = 0.00; Chi² = 2.78, df = 7 (P = 0.90); I² = 0%

Test for overall effect: Z = 2.41 (P = 0.02)

Test for subgroup differences: Not applicable



National Lung Cancer Screening Program

The National Lung Cancer Screening Program will maximise prevention and early detection of lung cancer.

On 2 May 2023, the Minister for Health and Aged Care, the Hon Mark Butler MP, announced Government investment of $263.8 million from 2023-24 to implement a National Lung Cancer Screening Program, for commencement by July 2025.

The announcement is a culmination of the feasibility assessment conducted by Cancer Australia and the positive recommendation from the Medical Services Advisory Committee supporting the introduction of the program.

Co-designed with the First Nations health sector, the program will maximise prevention and early detection of lung cancer and achieve equity in cancer outcomes for vulnerable groups.

Eligibility

The program delivers targeted screening to high-risk individuals on a two-yearly basis. Eligibility to participate in the program is assessed using risk-based eligibility criteria recommended by MSAC (15). People are eligible to participate if they:

1. Are between 50 and 70 years of age; and
2. Are asymptomatic (show no signs or symptoms of lung cancer); and
3. Currently smoke or have quit smoking in the past 10 years; and
4. Have a history of cigarette tobacco smoking of at least 30 pack-years.

Calculating pack-year smoking history

Calculate pack-years

	x		=	
NUMBER OF YEARS SMOKED		AVERAGE NUMBER OF PACKS SMOKED PER DAY (one pack equals 20 cigarettes)		PACK-YEARS

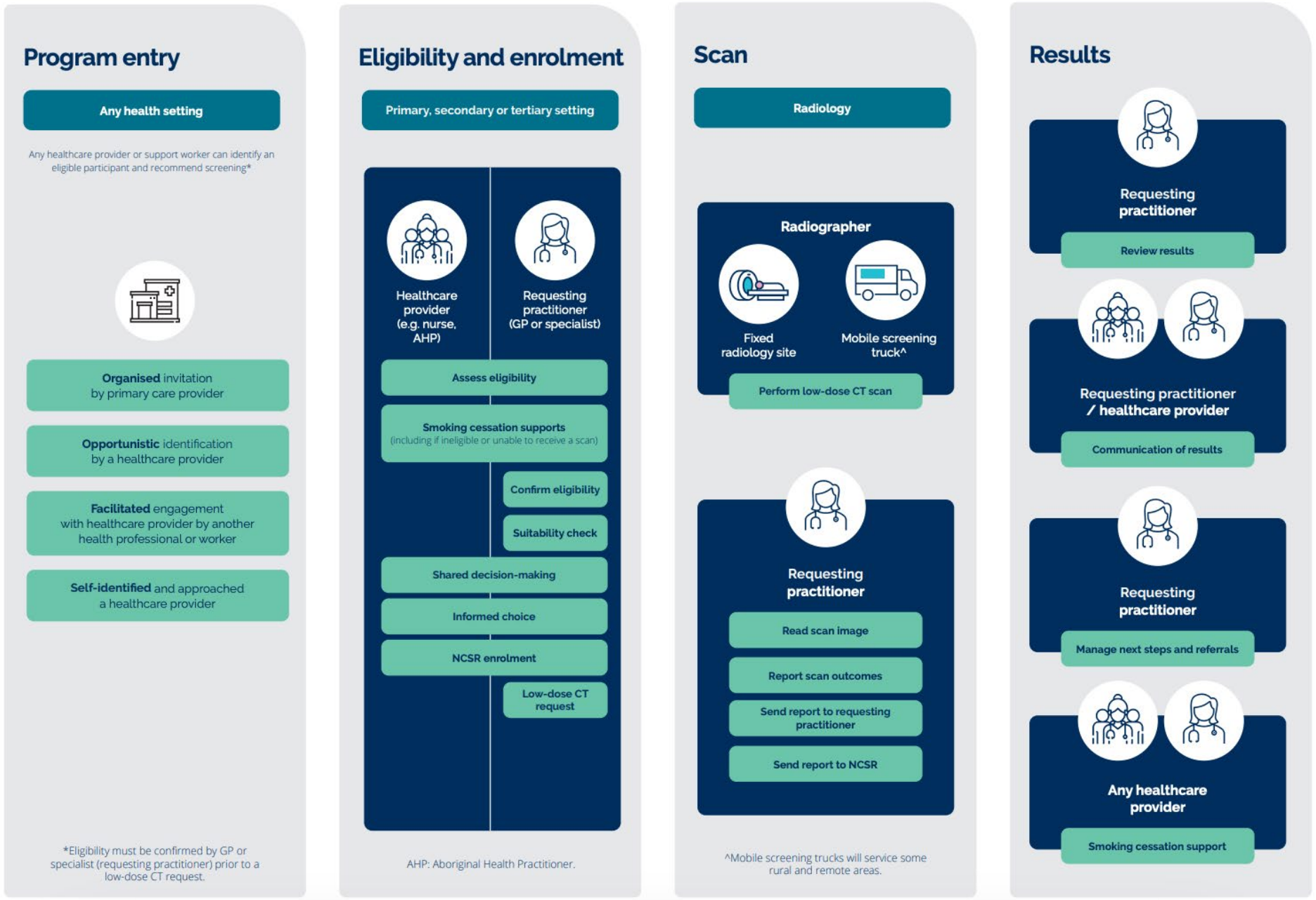
A case study example of how to calculate smoking history:

- A 55-year-old person sees their GP to assess their eligibility to participate in the program. They quit smoking 6 years ago. Prior to that they would on average smoke 2 packets of 20 cigarettes per day for 15 years.
- This equates to 30 'pack-years'. This smoking history makes the person eligible for the program and they agree to commence screening.

After being in the program for 5 years, the participant has continued to not smoke, and it had now been 11 years since they quit.

Program entry

Figure 2: Simplified pathway summarising the program healthcare setting and roles and responsibilities



Summary of requirements prior to screening.

	Baseline (first) screening	Biennial / follow-up screening
Eligibility Assessment	Yes	No *Once a participant is enrolled in the program, smoking eligibility does not need to be re-assessed. Need to confirm age eligibility.*
Suitability check for low-dose CT scan	Yes	Yes
Shared decision-making	Yes	Yes
Registration for program within the NCSR	Yes	No *Confirm participant information and contact details*
Low-dose CT scan request*	Yes	Yes

**requires participant to make an appointment to see an authorised medical practitioner to obtain the low-dose CT request*

Cost

Initial eligibility assessment

Need to see a healthcare provider to get a referral for a LDCT scan.

Healthcare providers who do not bulk bill may charge a general fee for consultations about the NLCSP.

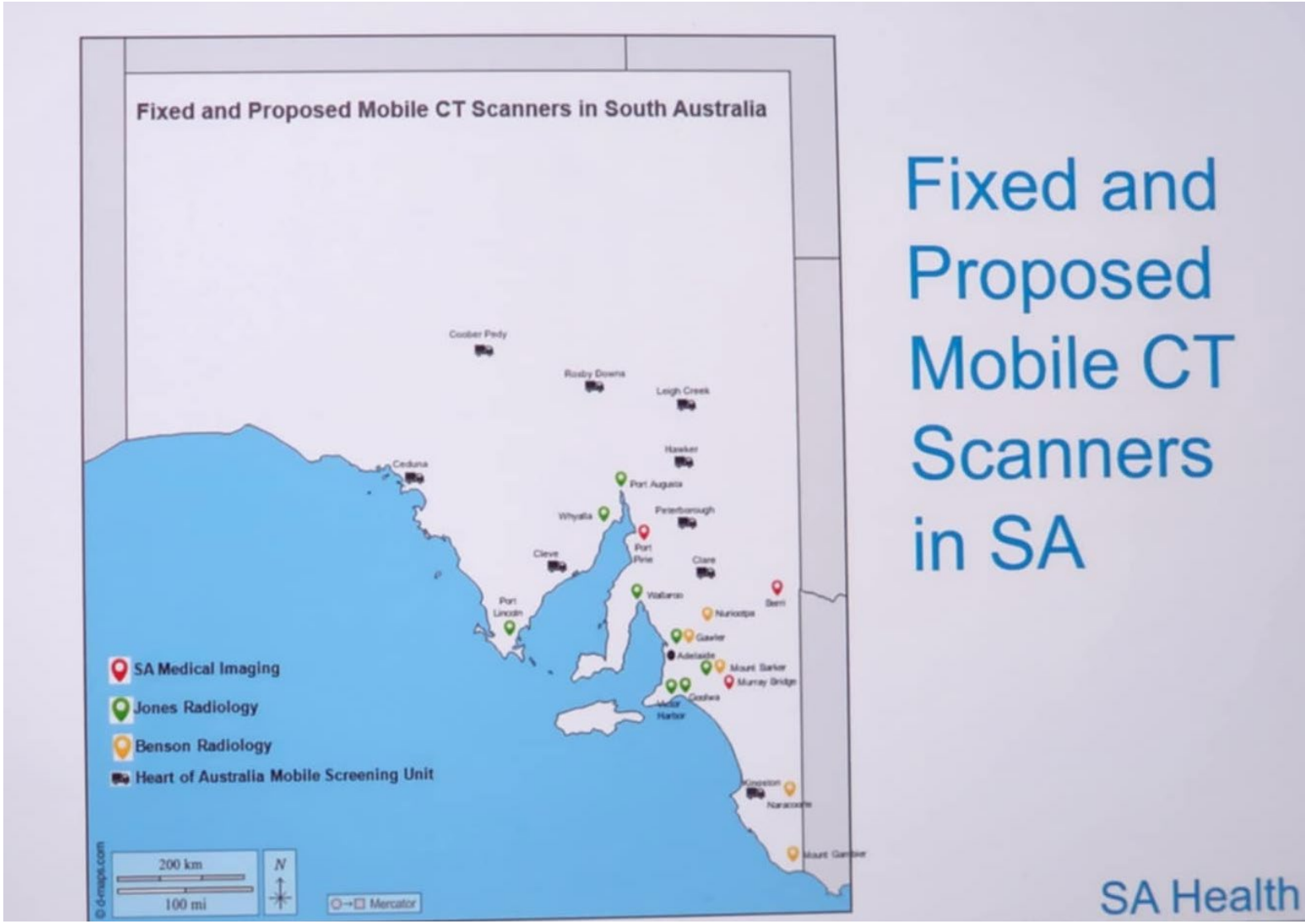
LDCT scan

2 new mandatory bulk billing MBS items for LDCT scans under the NLCSP (no out-of-pocket costs):

- 1 MBS item for the screening LDCT scan done by the participant every 2 years
- 1 MBS item for any follow-up LDCT scans that may be required in the 2-year screening period depending on the results of the screening LDCT scan.

Radiology sites

- Universal referral form
  - Includes family history of lung cancer



Thank you

2

How practices can use CAT4 to identify patients by age and smoking status in line with the eligibility criteria

Phil Flanagan - NWMPHN

Eligibility Criteria NLCSP Vs. PenCat recipe

You are eligible for the NLSCP if you:

are aged between 50 and 70 years

show no signs or symptoms of lung cancer (that is, you are asymptomatic)

And

have a history of at least 30 pack-years of cigarette smoking and are still smoking

or

have a history of at least 30 pack-years of cigarette smoking and quit in the past 10 years.

In PenCat you can filter patients who may be eligible for the NLCSP by:

Age range

Smoking Status

but you cannot

Calculate a history of at least 30 pack-years of cigarette smoking and are still smoking

or

have a history of at least 30 pack-years of cigarette smoking and quit in the past 10 years.

Eligibility Criteria NLCSP – Smoking Pack Years and Calculators

Smoking Pack Years

Smoking pack years are calculated by multiplying the number of packs of cigarettes smoked per day by the number of years the person has smoked. For example, 1 pack year is equal to smoking 1 pack per day for 1 year, or 2 packs per day for half a year, and so on.

Pack Year Calculators

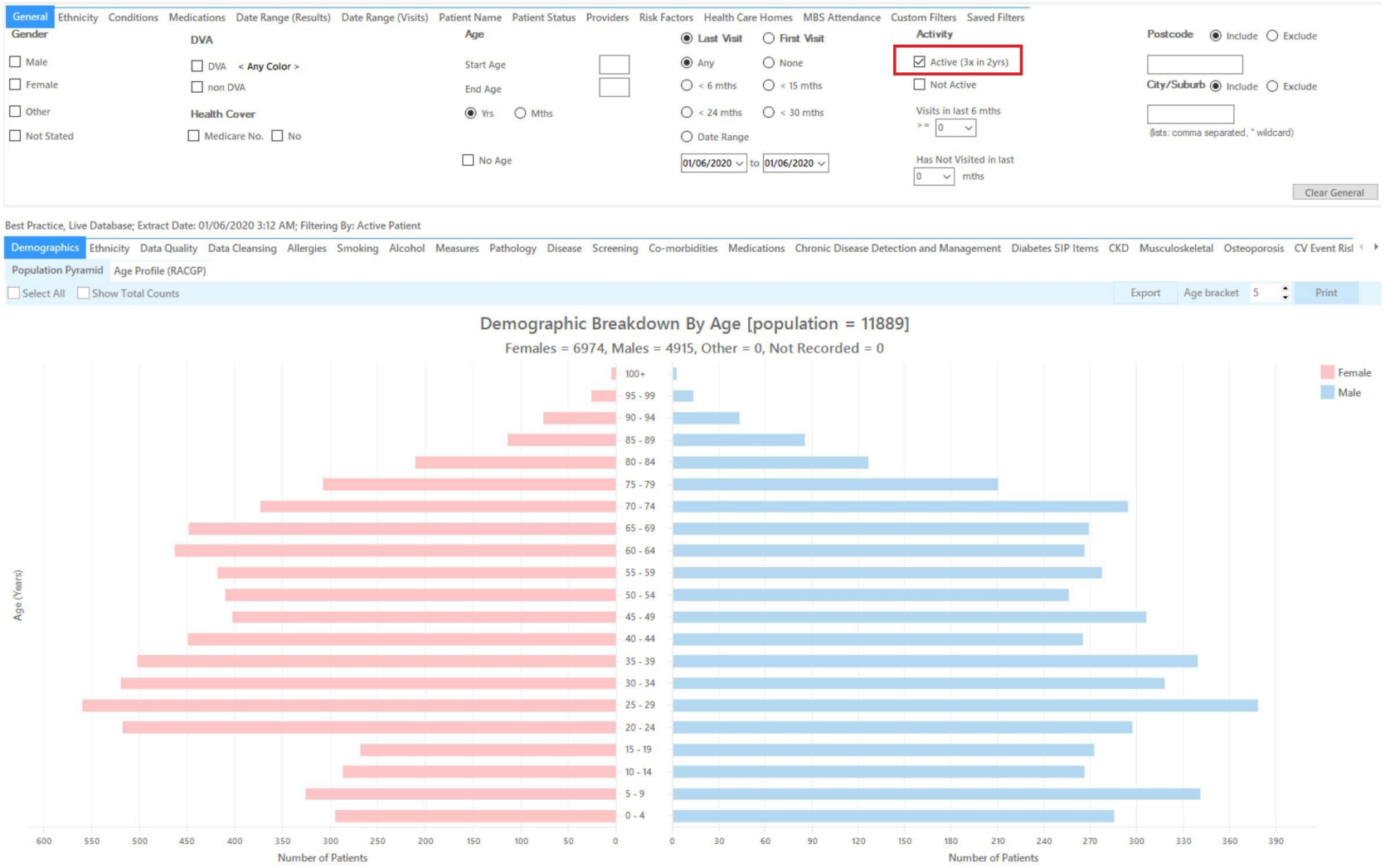
There are a variety of pack year calculators available online including:

https://www.mdcalc.com/calc/10187/pack-years-calculator

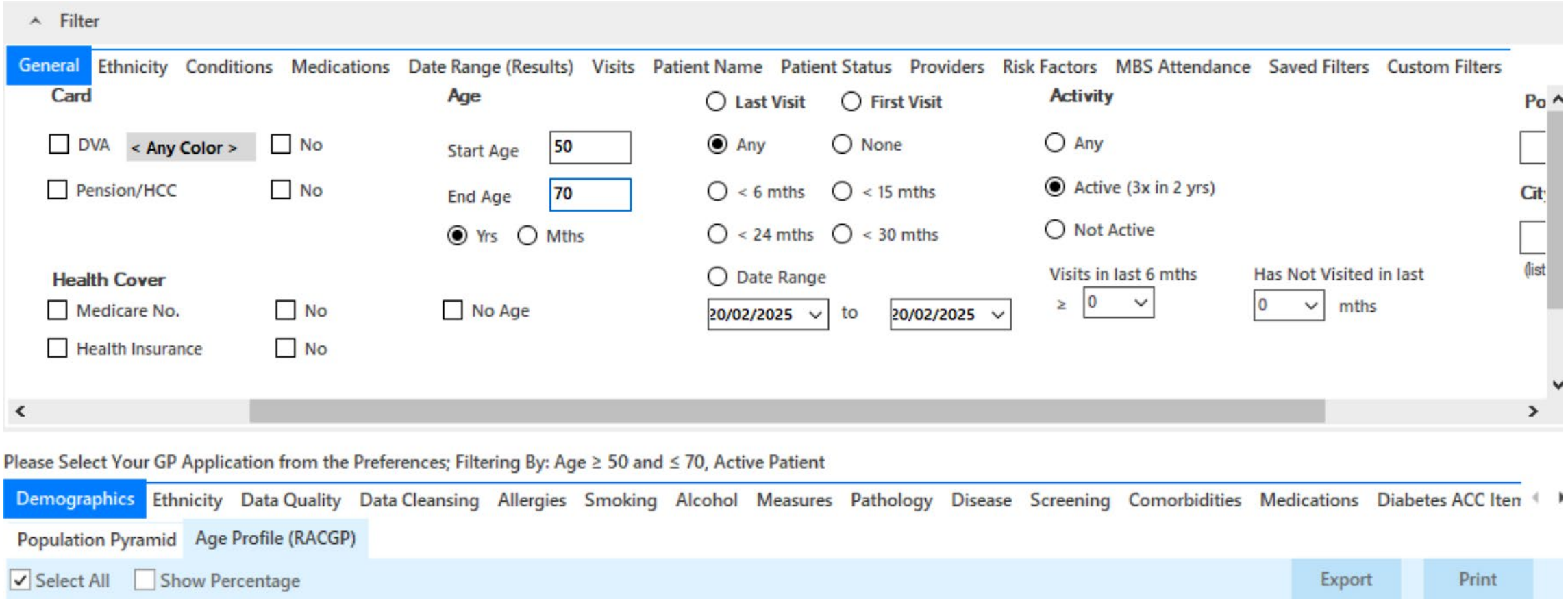
and

https://shouldiscreen.com/English/pack-year-calculator

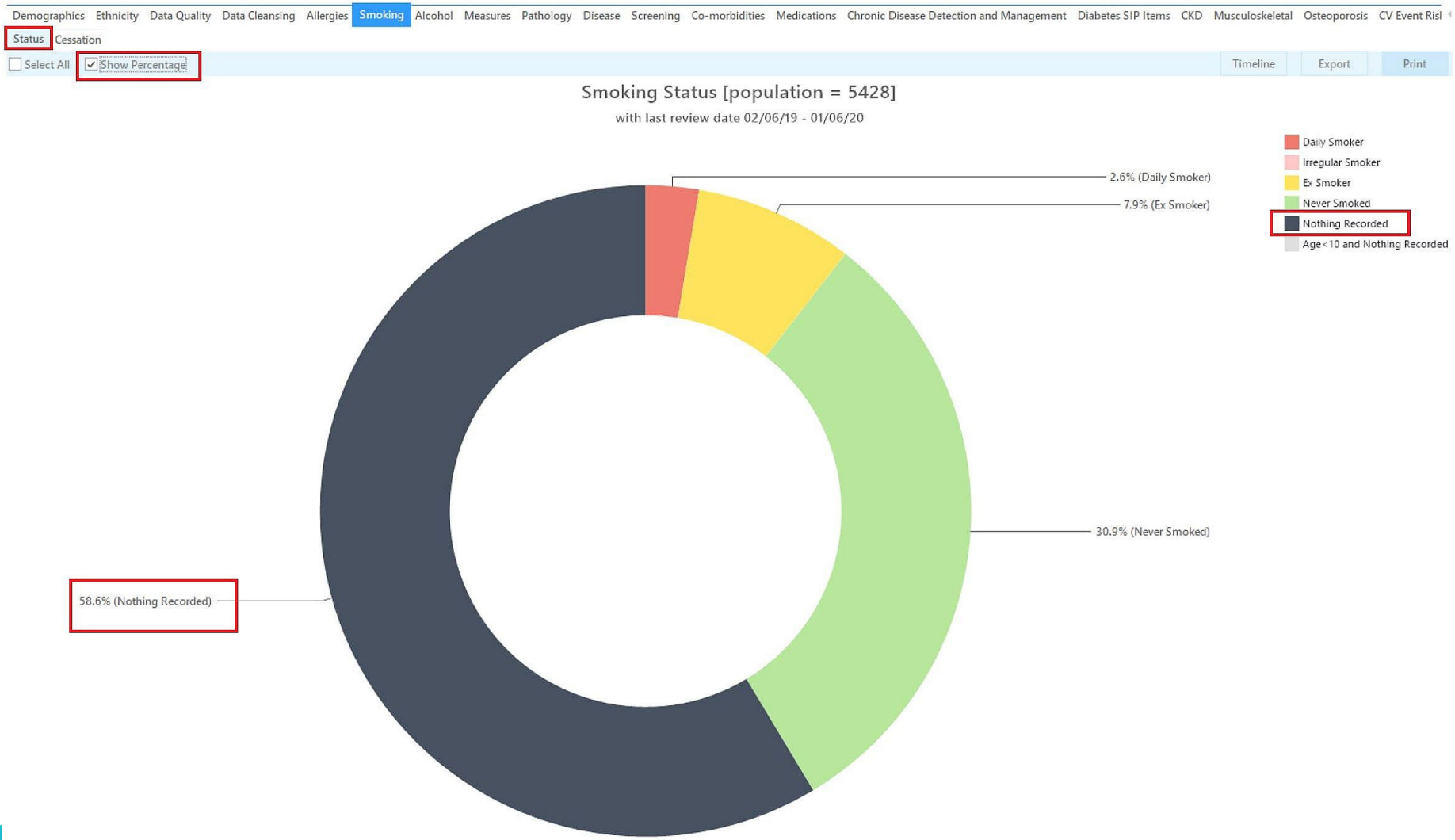
CAT 4 Starting Point



Part Two – Patients 50 -70 yearly smoking assessments



Smoking Status Demographics



Report Steps – Smoking/Status

Reidentify Report [patient count = 626]

Filtering By: Age >= 15 and <= 29, Active Patient, Last Results <= 12 mths, Selected: Smoking (Not recorded , Not recorded)

ID	Surname	First Name	Known As	Sex	Age	Address	City	Postcode	Phone (H/W)	Phone (M)	Medicare	Smoking	Review Date
				M	19			9999				Never smoked review on 22/09/2016	
				M	29			9999				Never smoked review on 12/02/2018	
				M	18			9999				Never smoked review on 19/10/2016	
				F	23			9999				Never smoked review on 16/06/2018	

Report Steps – Smoking/Status

Report Steps

Select the **“Smoking/Status”** tab

When switched to **“Show Percentage”**, it shows you the smoking status of your selected patient group and allows you to measure improvement over time by comparing your reports.

Note:

The date of an assessment only changes when modified or additional information is entered.

Anyone in that age group with an assessment of more than 12 months ago is counted as **“nothing recorded”**. Double-clicking on this’ part of the graph shows a list of all those patients with the date of the last assessment listed in the ‘Smoking column’.

Best Practice (BP)

Enquiries relating to the smoking status of Patients:

These can be found under the family & social history within the patient record, the knowledge article for this can be found at: ***Family and Social history***

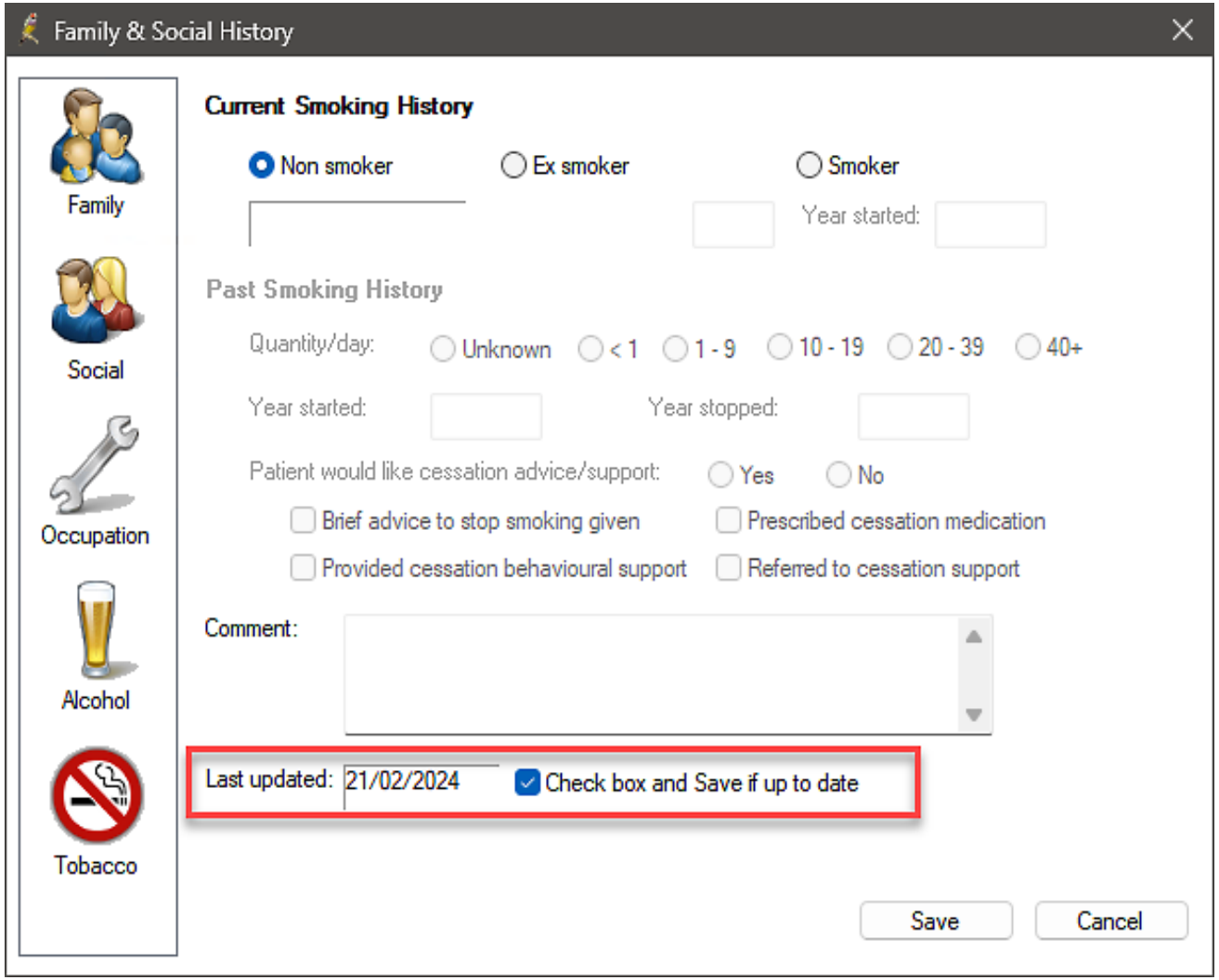
How to alter patient records with no smoking history:

```
SELECT *
FROM BPS_Patients
WHERE StatusText = 'Active'
AND InternalID In (Select InternalID FROM
Clinical WHERE SmokingStatus = 0)
ORDER BY surname, firstname
```

BP – Family and Social History

Providers record information on **Tobacco history** including:

Non-smoker or smoker
Ex smoker, when they started and stopped
Smoker's method, cigarettes per day and year started
A 'yes' or 'no' for advice/support if or when a patient would like to stop smoking.



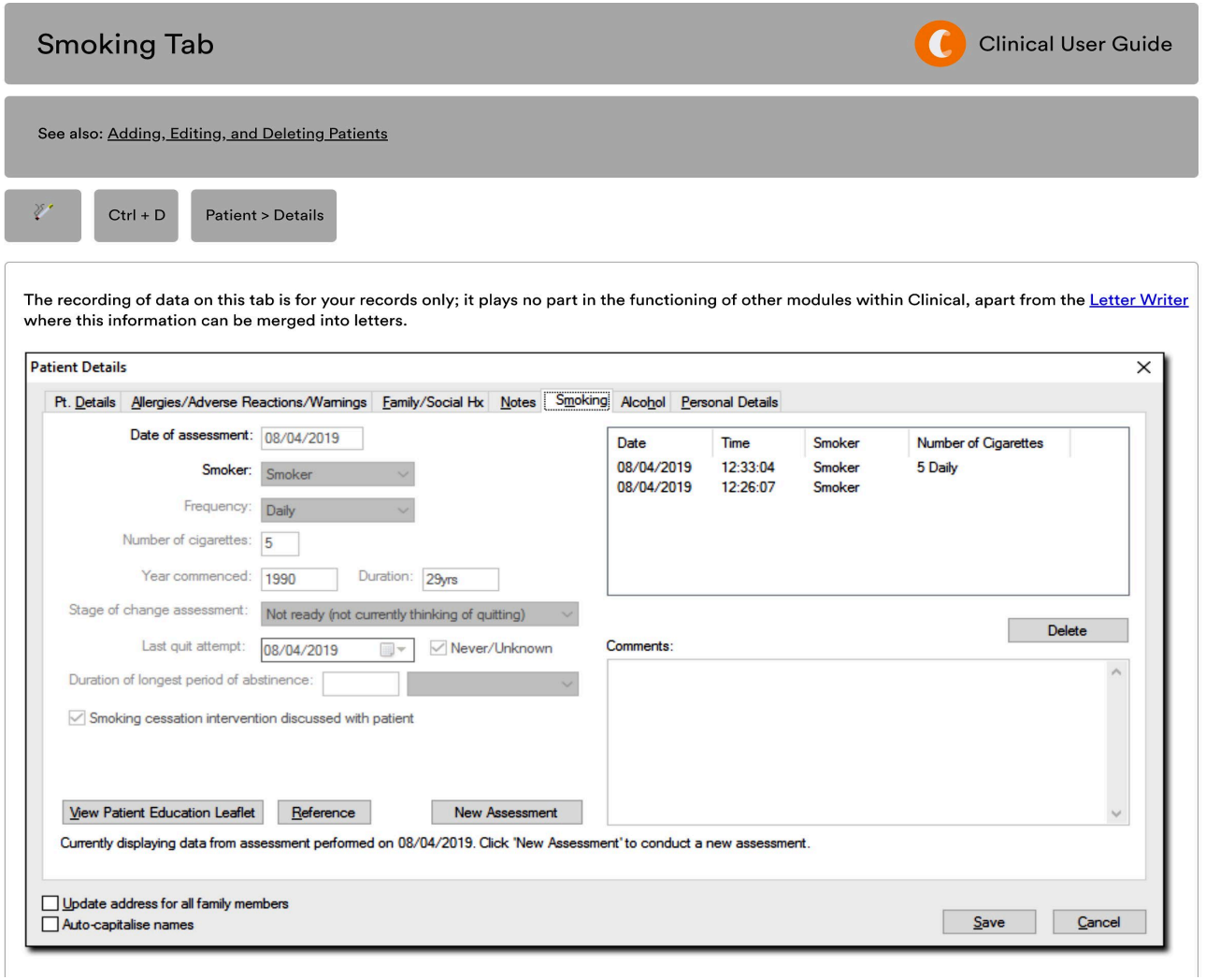
Medical Director – Smoking

Click **View Patient Education Leaflet** to open 'Smoking - Quitting' PDF.

Click **Smoking cessation intervention discussed with patient** check box to flag patients for the Smoking Cessation report found in MedicalDirector Insights.

Click **Update Address for All Family Members** check box to update address details for other family members. Clinical uses the **Head of Family** setting to determine patients of the same family. Option is only available when editing Patient Details from the Clinical Window.

Tick the **Auto-Capitalise Names** check box to automatically capitalise the first letter of each word you type.



3

Localised services/pathways and information relevant to the north western Melbourne catchment

Dr Asha Bonney - RMH

Referral Pathways in Lung Cancer Screening

Dr Asha Bonney

North Western Melbourne Primary Healthcare Network Series 1

25/02/2025

The Royal Melbourne Hospital

Potential Challenges

Possible barriers		
Population	Professionals	Regulatory

High risk population
- Suboptimal knowledge/awareness
  * Principles of CT lung cancer screening
  * Harm-benefits ratio
- Conditions for informed-decision making
- Challenge to recruit the hard-to-reach target population
  * More fatalistic
  * Suboptimal screening uptake
- Suboptimal screening uptake
  * Suboptimal awareness
  * Distance to CT scan facilities
  * Lacking public or cheap transport facilities
  * Personal contribution health care costs
 	
Low-risk/never smokers
- May feel discriminated
- Lower willingness to pay for screening a "lifestyle" disease
 	
Lung cancer patients (and relatives)
- Stigma of a "lifestyle" disease
	- Suboptimal involvement primary care
	  * Lack of time and engagement primary care to discuss pros and cons
	  * Increase in opportunistic CT testing
	- Incomplete and uniform protocols
	  * Protocol for CT acquisition
	  * Protocol for nodule management
	  * Protocol for incidental findings
	  * Protocol for work-up and diagnosis
	  * Protocol for treatment
	  * Training programmers in image acquisition, image quality, and radiological image interpretation
	- Lack of evidence
	  * Combining smoking cessation intervention
	  * Use of biomarkers
	  * Screening tobacco-related co-morbidities (cardiovascular disease and COPD)
		- Suboptimal coverage population registries
		- Suboptimal nationwide/governmental coordination/quality assurance
		- Overestimation of tobacco control policies and underestimation of lung cancer screening potential
		- Defining performance indicators
		- Capacity
		  * Screening
		  * Work-up and diagnosis
		  * Treatment

Van der Aalst et al. TLCR. 2021.

Upcoming information

GET YOUR PRACTICE READY FOR THE NATIONAL LUNG CANCER SCREENING PROGRAM

Lung cancer is the leading cause of cancer death in Australia.[1] Currently, the majority of lung cancer cases are diagnosed at stages 3 and 4.[2] However, if found early, lung cancer can be successfully treated.[3]

Large international randomised trials have shown that screening using a low-dose CT scan can reduce lung cancer deaths by at least 20%, and can detect up to 70% of lung cancers at early stages.[4,5]

To address the incidence and mortality rates associated with lung cancer, from July 2025, eligible people aged between 50-70 years will be able to participate in the National Lung Cancer Screening Program (the program) using a low-dose CT scan, following shared decision-making with their healthcare provider. People with symptoms that suggest lung cancer should not be referred to the program. Instead, their symptoms should be investigated according to the Cancer Australia guide to **Investigating symptoms of lung cancer** (https://www.canceraustralia.gov.au/ISLC).

The program is an Australian Government initiative being implemented in partnership with the National Aboriginal Community Controlled Health Organisation (NACCHO).

The program is being co-designed in partnership with communities and the healthcare workforce to be person-centred, equity-focused, accessible, and culturally safe. It is being co-designed to improve lung cancer outcomes for those disproportionately impacted by lung cancer including Aboriginal and Torres Strait Islander peoples and communities.

The program is primary care-led. This checklist provides information on how to prepare your practice for the program.

People are eligible to participate in the program if they:

Australian Government | NATIONAL LUNG CANCER SCREENING PROGRAM

References:

1. Sung, H. et al. Global Cancer Statistics 2020: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries. *CA: A Cancer Journal for Clinicians* 71, 209-249 (2021).
2. Australian Institute of Health and Welfare. *Cancer in Australia 2021* [Internet]. Canberra, Australia: Australian Institute of Health and Welfare; 2021. Available from: https://www.aihw.gov.au/reports/cancer/cancer-in-australia-2021/summary
3. Medical Services Advisory Committee. 1699 – National Lung Cancer Screening Program: Public Summary Document [Internet]. Canberra, Australia: Australian Government Department of Health; 2022 Jul [cited 2024 Mar 28]. Report No.: 1699. Available from: http://www.msac.gov.au/internet/msac/publishing.nsf/Content/1699-public
4. Aberle, D. et al. National Lung Screening Trial Research Team. Reduced lung cancer mortality with low-dose computed tomographic screening. *New England Journal of Medicine* 365, 395–409 (2011).
5. De Koning, H. J. et al. Reduced lung-cancer mortality with volume CT screening in a randomized trial. *New England Journal of Medicine* 382, 503–513 (2020).

The checklist below will help you prepare for July 2025

Given the central and critical role that primary care will play in the program, it is important the primary care workforce is aware of the program now, so they have ample time to prepare their practice. This will ensure that the primary care workforce is ready to promote the program with eligible participants and make referrals as soon as the program begins. GPs will have an important role in the program, as they will refer people eligible for screening to have a low-dose CT scan.

Review information about the program

The Australian Government is currently preparing health professional and consumer information materials and health professional online education which will be available prior to the program commencing in July 2025. The education will offer Continuing Professional Development points.

More information about the program is available on the **Department of Health and Aged Care's website** (https://www.health.gov.au/our-work/nlcsp).

Register with the National Cancer Screening Register

Register and integrate with the National Cancer Screening Register (NCSR).

More information can be found on the **NCSR website** (https://www.ncsr.gov.au/), including links to user guides and walkthrough video guides. If you require assistance registering or integrating your clinical software, call **1800 627 701** to speak to a member of the NCSR Contact Centre.

Identify potential participants

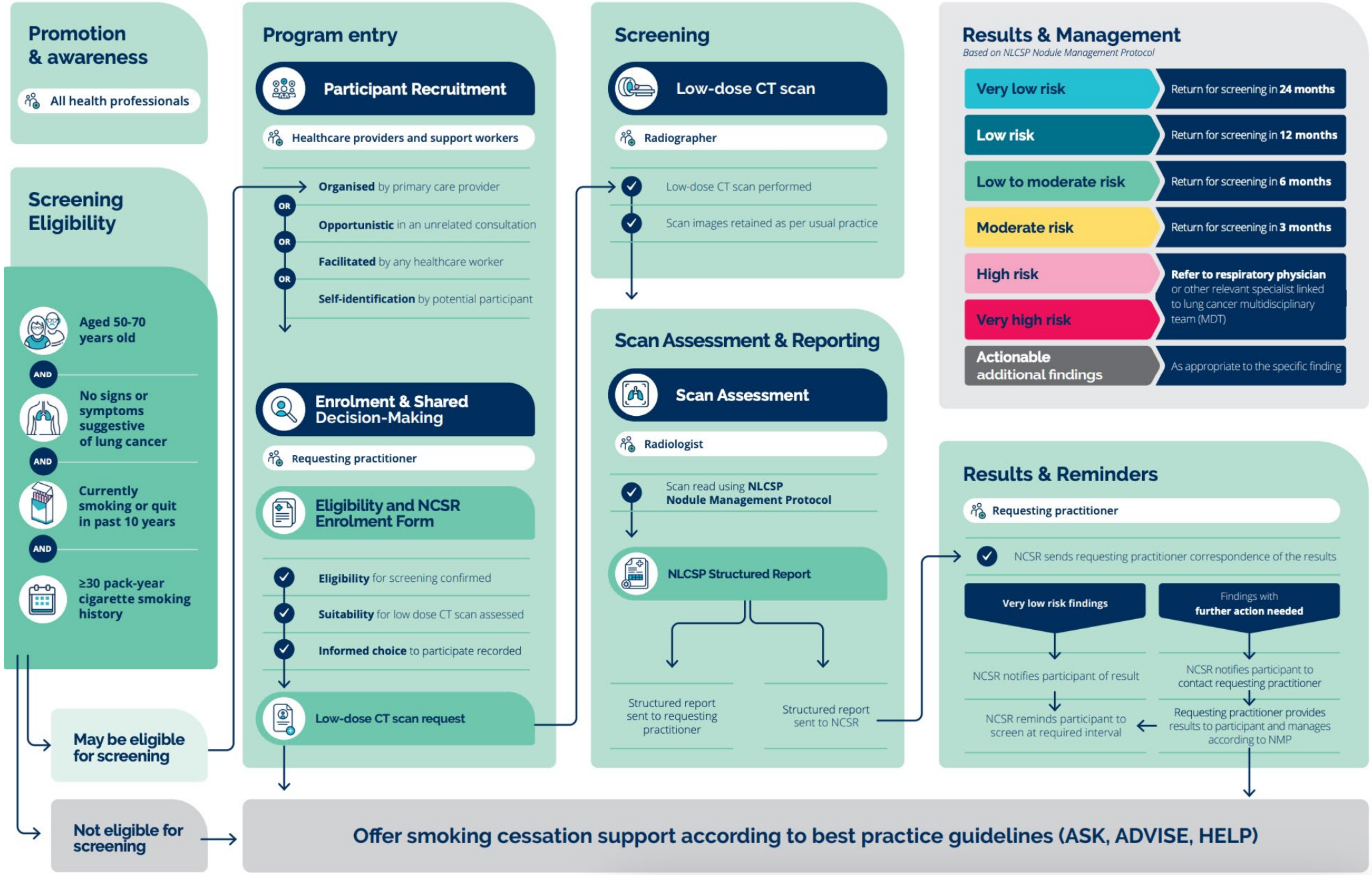
Work with your practice to identify patients who could be eligible from July 2025. This includes reviewing and updating smoking history in your clinical patient records.

Unlike other types of cancer screening, this is a targeted screening program which includes an assessment of someone's smoking status along with their age. Because of this, the NCSR will not be sending invitations to potential participants.

Establish electronic medical record (EMR)-based prompts to help identify potential participants as they become eligible.

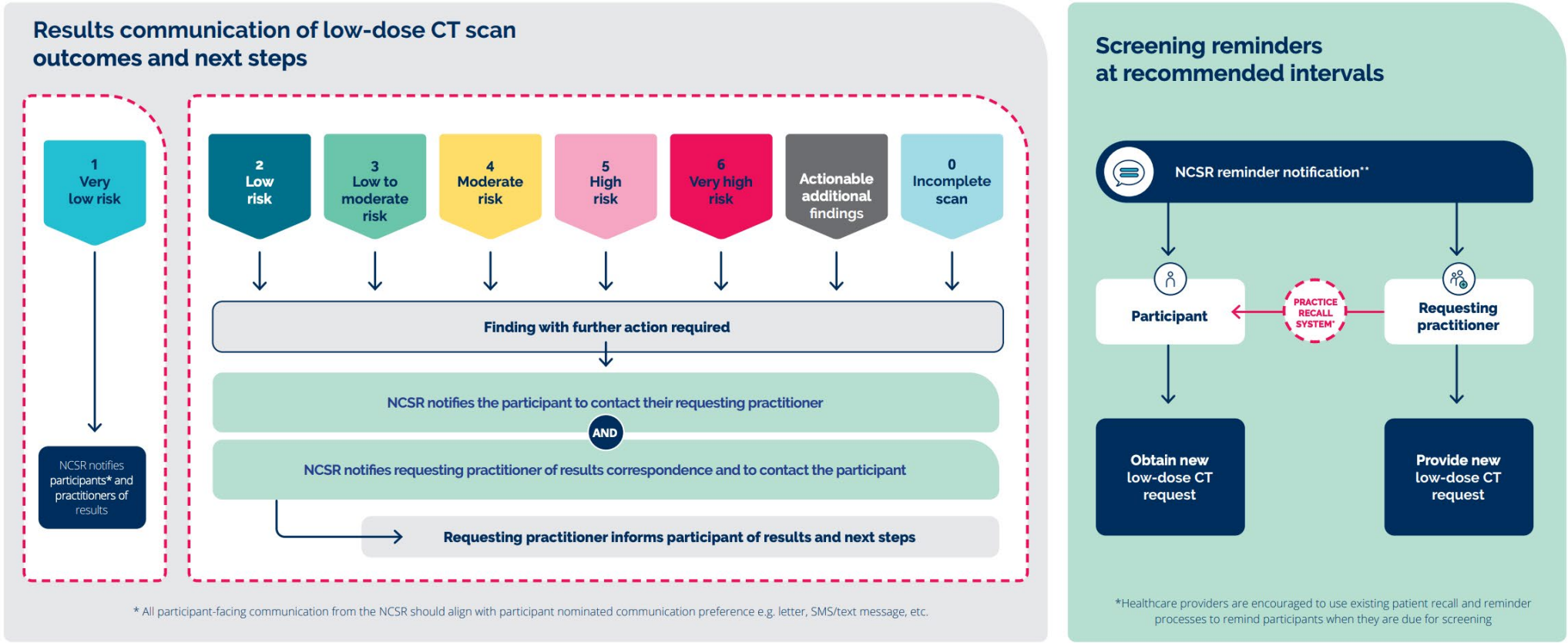
Overview of the National Lung Cancer Screening Program Pathway

Figure 1: National Lung Cancer Screening Pathway



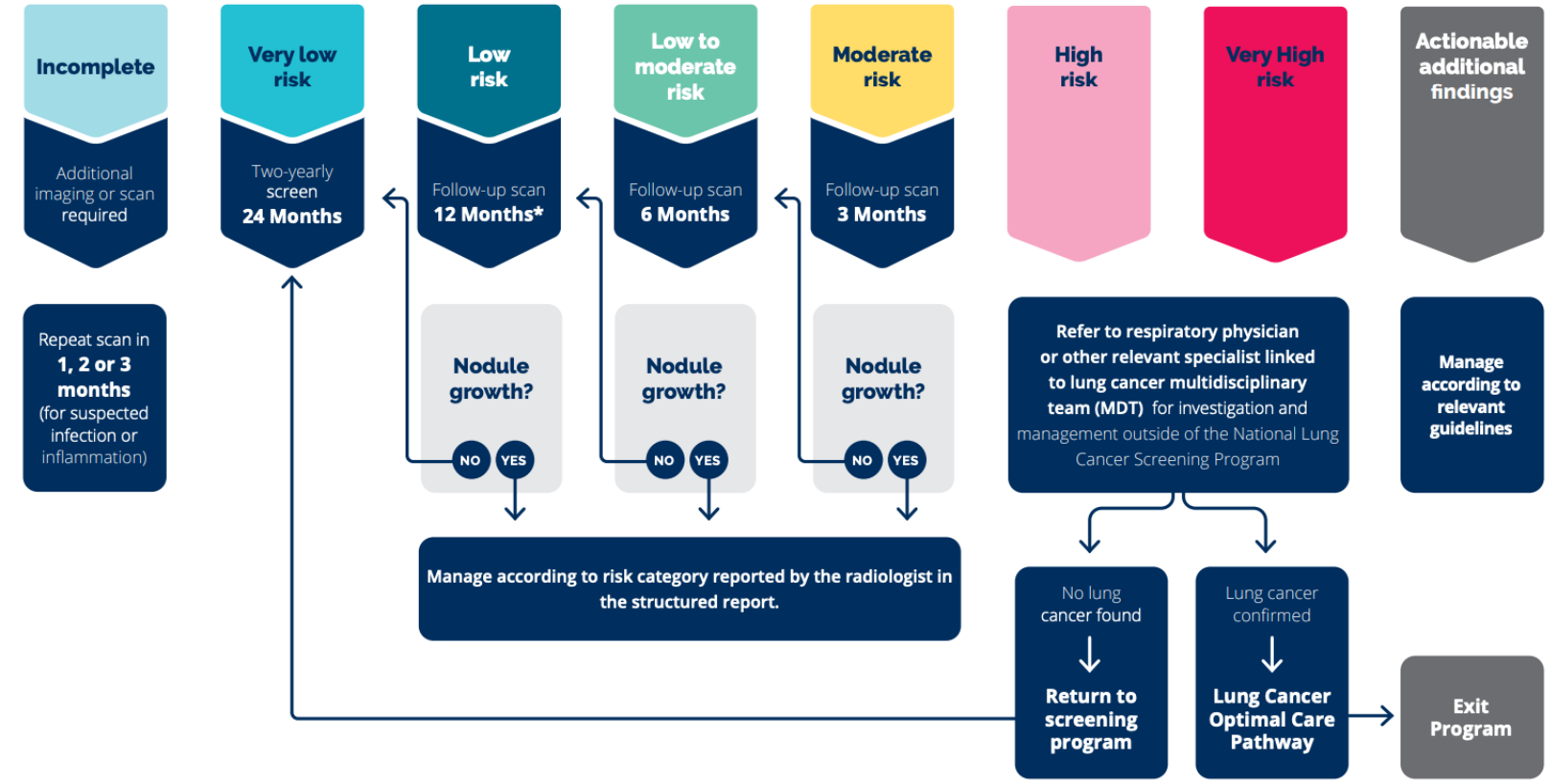
Communication

Figure 4: Simplified results communication process and responsibilities



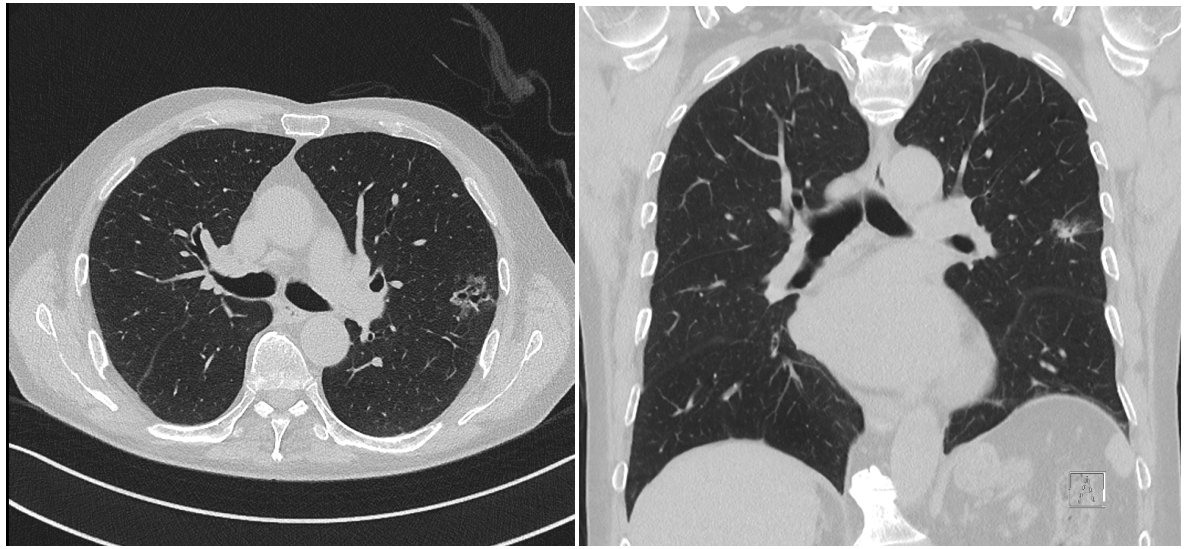
Nodule Management

Figure 3: Simplified nodule management protocol flowchart



*Low risk participants require two 12 month scans before extending to 24 months.

PanCan nodule management (case 1)



High risk-> (CAT 5)

Patient Characteristics

Age (18-100)*	70
Gender*	Male
Family History of Lung Cancer*	No
Emphysema*	No

Nodule Characteristics

Nodule size (1-30mm)*	27
Nodule Type*	PartSolid
Nodule in Upper Lobe*	Yes
Nodule Count*	3
Spiculation*	No

Calculate

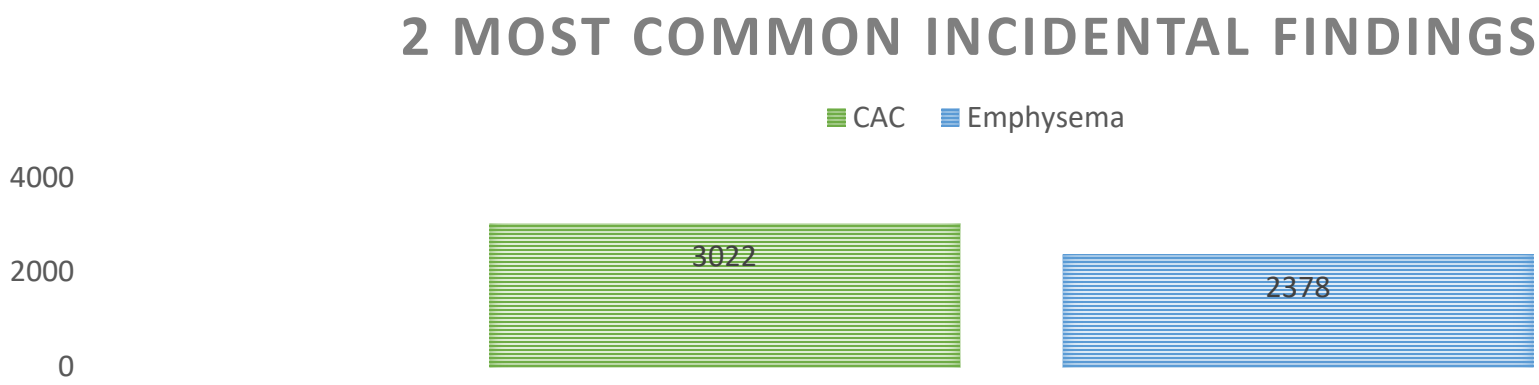
Brock Model Probability: 44.9%

https://www.brit-thoracic.org.uk/quality-improvement/guidelines/pulmonary-nodules/pn-risk-calculator/
McWilliams et al N Engl J Med 2013; 369:910-919

Screening with LDCT, beyond lung cancer

Additional Findings

	Australia,	Canada	P-value
	N=2027	N=2301	
Any incidental findings present	1514 (74.7%)	1636 (71%)	<0.001
Actionable incidental findings	N=1701	N=2270	<0.001
Present	351 (20.6%)	103 (4.5%)	
Absent	1350 (79.4%)	2167 (95.5%)	



In press. MJA. 2025.

Incidental CAC on LCS LDCT

TABLE 3 Follow-up of incidental CAC in participants without a known history of CAD.

	# Responses[a]	Mild[b]	Moderate[b]	Severe[b]	Goodman–Kruskal's gamma estimate	Total # participants (% overall with known data)
Saw GP for results	174	80 (76%)	47 (82%)	9 (75%)	0.100	136 (78%)
Notified of incidental CAC	178	27 (25%)	16 (28%)	7 (54%)	0.180	50 (28%)
Additional investigations for CAC post screening	178	17 (16%)	8 (14%)	5 (39%)	0.095	30 (17%)
Medication changes for incidental CAC	178	8 (7%)	4 (7%)	5 (39%)	0.262	17 (10%)
Provided lifestyle advice (including smoking cessation)	174	6 (6%)	3 (5%)	1 (8%)	0.042	10 (6%)
Referred to cardiologist	178	13 (12%)	7 (12%)	6 (46%)	0.323	26 (15%)
Invasive testing (coronary angiogram)	174	3 (3%)	5 (9%)	3 (25%)	0.624	11 (6%)

[a]Number of participants with a complete response to the outcome. Response was considered unknown (missing data) if unable to be confirmed with either participant or health care provider.
[b]% of participants with known data.

Bonney A, et al. Respirology. 2025.

American College of Radiology Quick Reference

Lung/Pleura	
Lung[11]	• Atelectasis – mild/subsegmental – OK. • Emphysema/bronchial wall thickening (Expected findings) – consider PCP evaluation; may benefit from Pulmonary consult. → **Fibrotic interstitial lung disease (ILD) → recommend pulmonary consultation.** → **Bronchiectasis/ground glass opacity/cystic lung disease/diffuse nodular disease → PCP evaluation, consider pulmonary consultation.**
Pleura	→ **New disease – effusion, thickening, mass → PCP evaluation, consider pulmonary consultation.**
Mediastinum	
Lymph nodes (Short axis measurement)[12]	• < 15 mm – OK. → **≥ 15 mm & no explainable cause → PCP evaluation; consider pulmonary consultation. Consider follow-up CE Chest CT in 3–6 months.**
Other[12]	• Cyst – OK. → **Mass (soft tissue or mixed density) → CE Chest MRI or CT.**
Thyroid[16]	
Features	• Large and heterogeneous, likely goiter – probably OK; consider thyroid function testing. • Nodule < 15 mm – OK. → **Nodule ≥ 15 mm or with suspicious features → w/u: thyroid US and clinical evaluation.**

Munden et al. J Am Coll Radiol 2018.

LCS referral process at RMH

- New primary health care educational series
- New lung cancer screening CNC support
- New lung nodule – nurse-led clinic
- New lung cancer screening – physician-led clinic

The Royal Melbourne Hospital

Thank you

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HealthPathways Melbourne

Adila Lundin - NWMPHN

HealthPathways Melbourne

National Lung Cancer Screening Program

25 February 2025

Adila Lundin – Program Officer

phn EASTERN MELBOURNE
An Australian Government Initiative

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

Where to find the respiratory suite:

Recently updated and under review pathways

Clinical pathways

- Lung Cancer – Established
- Lung Cancer - Suspected

- Acute Exacerbation of COPD
- Advanced or End-stage COPD
- Assessing Respiratory Presentations in General Practice
- Asthma in Adults - Acute
- Asthma in Adults - Non-acute
- Asthma in Pregnancy
- Bronchiectasis
- Chronic Cough
- COPD Severity Classification
- COPD-Asthma Overlap
- Non-acute COPD
- Thunderstorm Asthma

Referral pathways

- Respiratory Referrals
- Paediatric Respiratory Referrals
- Acute Respiratory Referral or Admission (Same-day)
- Non-acute Respiratory Referral (> 24 hours)
- Lung Function Testing
- Pulmonary Rehabilitation
- Home Oxygen Referral

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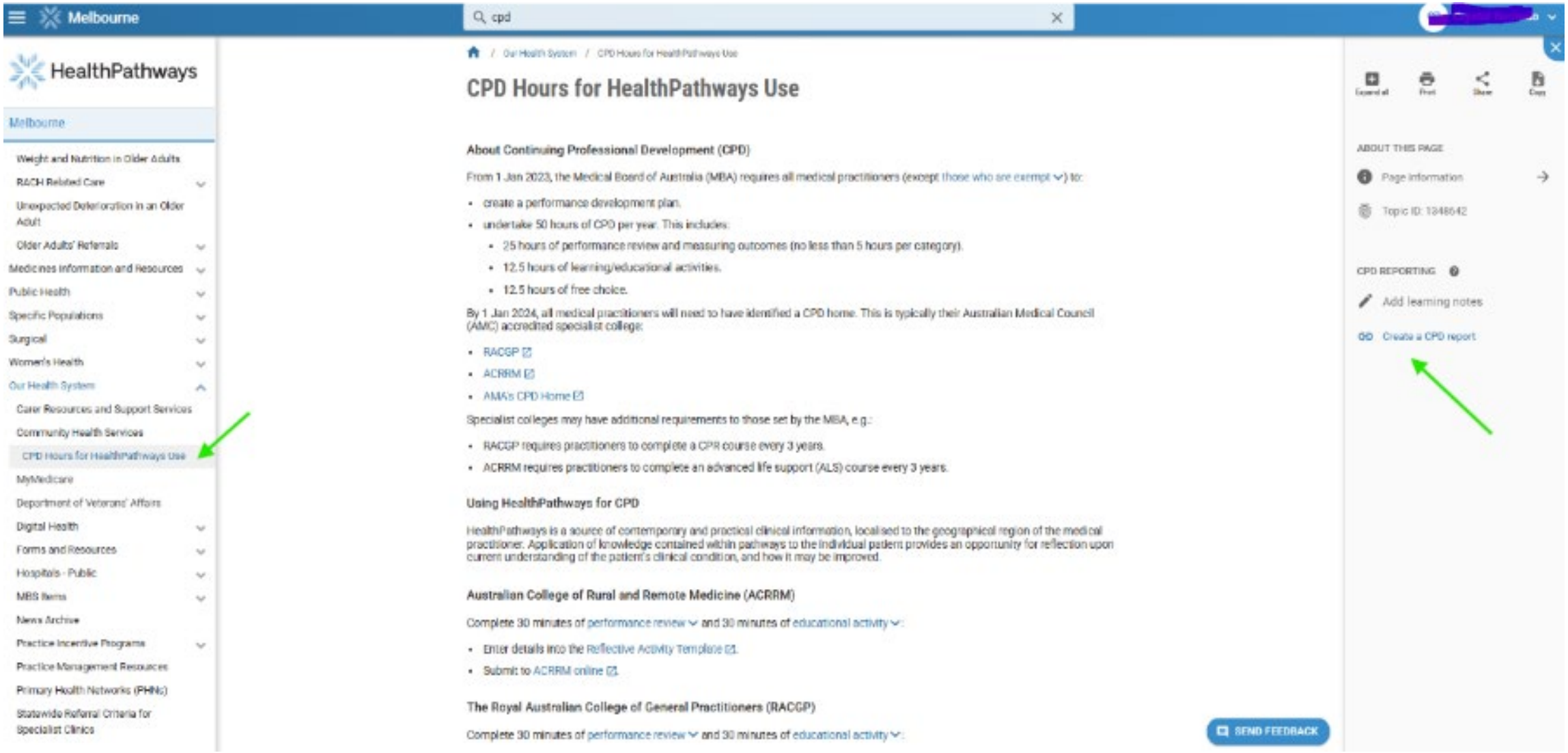
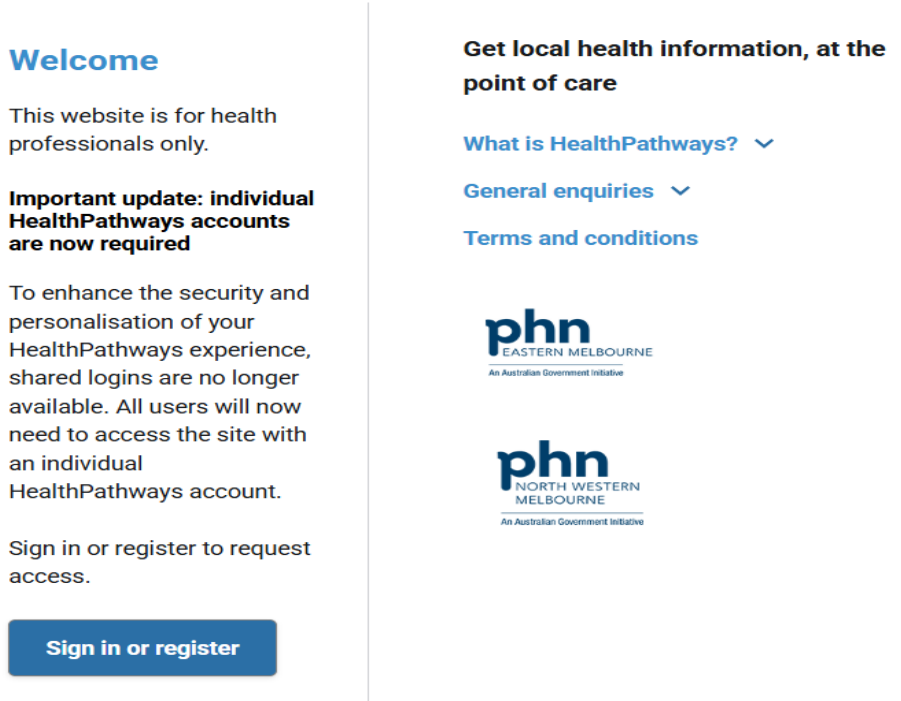
CPD Hours for HealthPathways Use



HealthPathways Melbourne

Accessing HealthPathways



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Post-Presentation Poll Questions

Q&A

Session Conclusion

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Attendance certificate will be received within 4-6 weeks.

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