National Lung Cancer Screening Program – Current Status and Emerging Challenges

Tuesday, April 28 2026

The content in this session is valid at date of presentation

Acknowledgement of Country

We 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.

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Housekeeping – Zoom Meeting

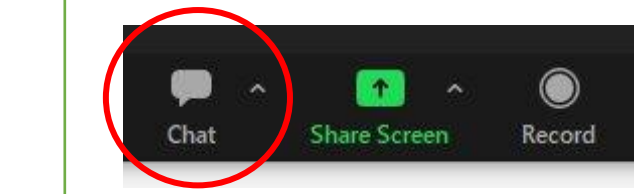
All attendees are muted

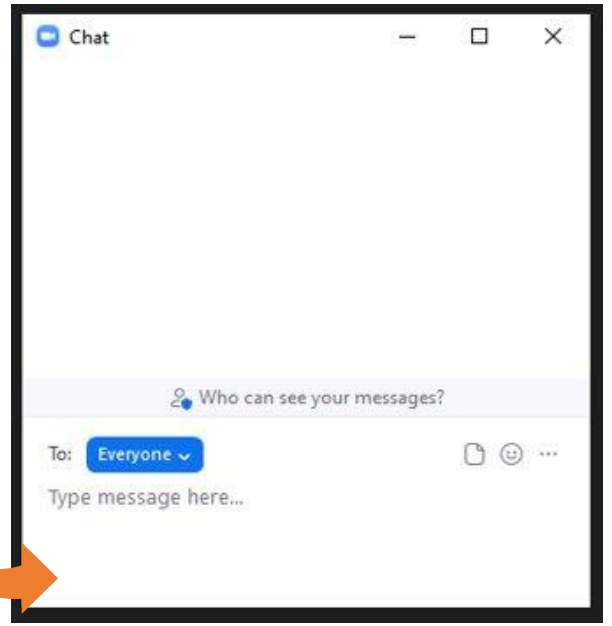
Please ask questions via the Chat box only

- Questions will be at the end of the presentation

This session is being recorded.

You will receive a link to this recording and copy of slides in post session correspondence.





Housekeeping – Zoom Meeting

Is your session name the same as your registration?

To ensure we can issue your certificates and CPD please ensure you have joined the session using the same name as your event registration (or phone number, if you have dialled in).

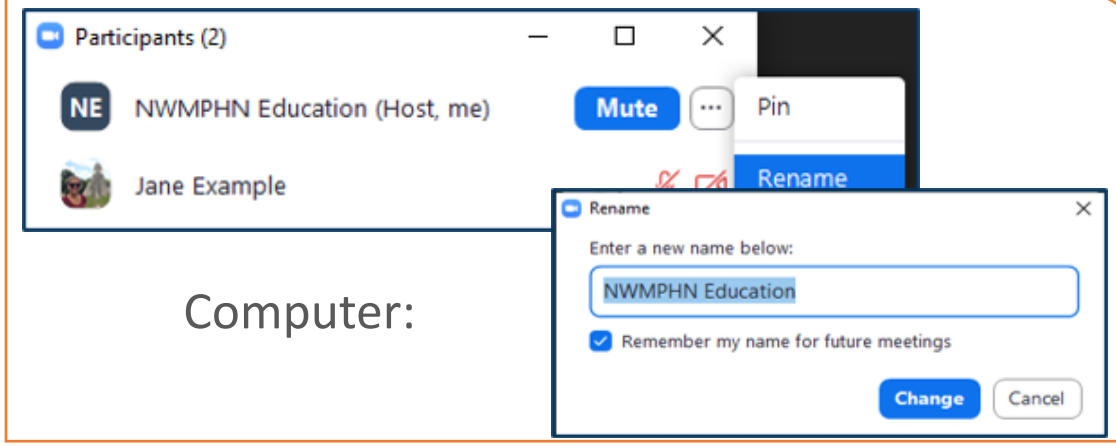
Not sure if your name matches, send a Chat message to 'NWMPHN Education' to identify yourself.

Housekeeping – Zoom Meeting

How to rename yourself

1. Click on **Participants**
2. If using
   - **App:** click on your name
   - **Computer:** 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**

Computer:



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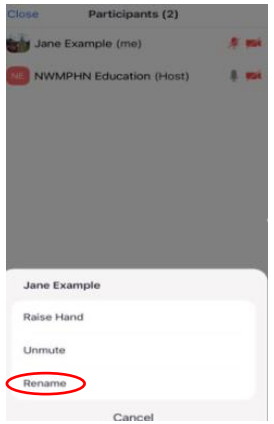


Agenda

Time	Topic
6:30pm-6:35pm	Welcome & Housekeeping *Dr Sue Hookey*
6:35pm-6:40pm	Pre presentation poll *Dr Asha Bonney*
6:40pm-6:50pm	Overview of National Lung Cancer Screening Program *Dr Asha Bonney*
6:50pm-7:15pm	How to refer and manage patients in the National Lung Cancer Screening Program *Dr Hashinee Weraduwage*
7:15pm-7:25pm	Smoking cessation for the patient that has tried everything *Dr Alistair Miller*
7:25pm-7:35pm	Patient selection and risk stratification *Dr Renee Manser*
7:35pm-7:40pm	Post presentation poll *Dr Asha Bonney*
7:40pm-7:45pm	RMH referral pathways *Dr Asha Bonney*
7:45pm-8:00pm	Q&A

Speakers

Dr Asha Bonney is a Respiratory and Sleep Physician at the Royal Melbourne Hospital. Her other roles include Senior Research Fellow 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 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.

A/Prof Renee Manser is a Respiratory and Sleep Physician at the Royal Melbourne Hospital and Peter MacCallum Cancer Centre. She has a PhD in lung cancer screening and is an honorary Associate Professor in the Department of Medicine, University of Melbourne. A/Prof Renee Manser has extensive clinical experience in lung cancer diagnosis and management and is a Principal Investigator on the International Lung Screen Trial. A/Prof Manser is co-editor for the Cochrane Lung Cancer Review Group and a regular scientific reviewer for the Melbourne Health Human Research Ethics Committee.

Dr Alistair Miller is a respiratory and sleep physician at the Royal Melbourne Hospital and Peter MacCallum Cancer Centre.

Dr Hashinee Weraduwage is a Melbourne-based GP and a HealthPathways Melbourne Clinical Editor.

Pre-Presentation Poll Questions

Overview of National Lung Cancer Screening Program

Dr Asha Bonney

The Royal Melbourne Hospital

Overview

- Program overview
- Current progress
- Referral pathway
- Case Examples

Lung cancer in Australia

Figure 3.2: Leading underlying causes of death in Australia, by age group, 2023

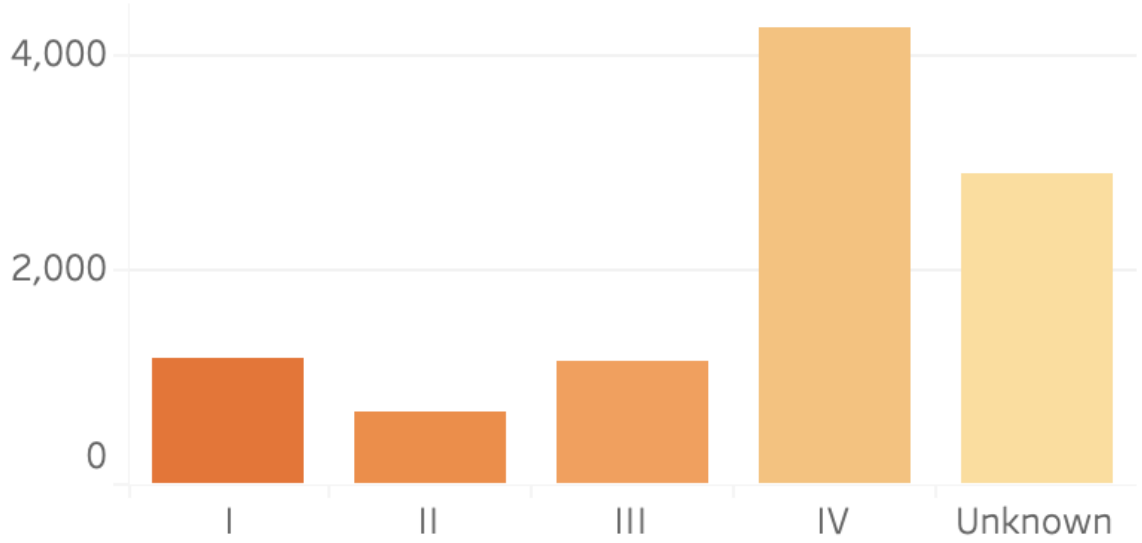
Sex: (•) Persons ( ) Males ( ) Females

Age group	Rank 1st	2nd	3rd	4th	5th
Under 1	Perinatal and congenital conditions	Other ill-defined causes	Sudden infant death syndrome	Selected metabolic disorders	Accidental threats to breathing
1–14	Land transport accidents	Perinatal and congenital conditions	Brain cancer	Other ill-defined causes	Accidental drowning
15–24	Suicide	Land transport accidents	Accidental poisoning	Other ill-defined causes	Assault
25–44	Suicide	Accidental poisoning	Land transport accidents	Coronary heart disease	Liver disease
45–64	Coronary heart disease	Lung cancer	Suicide	Liver disease	Colorectal cancer
65–74	Lung cancer	Coronary heart disease	COPD	Colorectal cancer	Cerebrovascular disease
75–84	Coronary heart disease	Dementia including Alzheimer's disease	Lung cancer	Cerebrovascular disease	COPD
85–94	Dementia including Alzheimer's disease	Coronary heart disease	Cerebrovascular disease	COVID-19	COPD
95+	Dementia including Alzheimer's disease	Coronary heart disease	Cerebrovascular disease	Heart failure and ill-defined heart disease	COVID-19

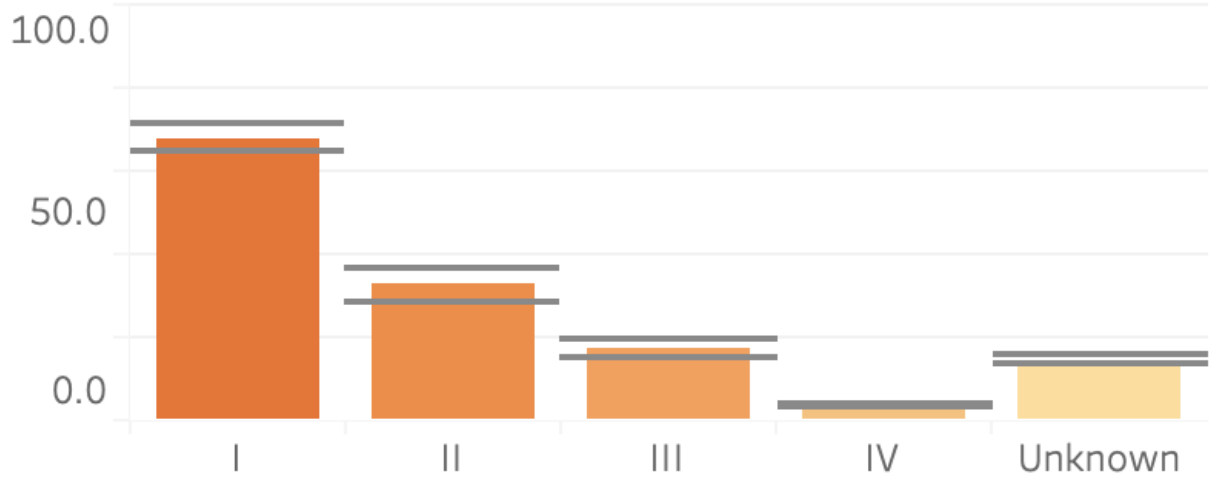
Institute of Health and Welfare (2025)

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

National Lung Cancer Screening Program

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

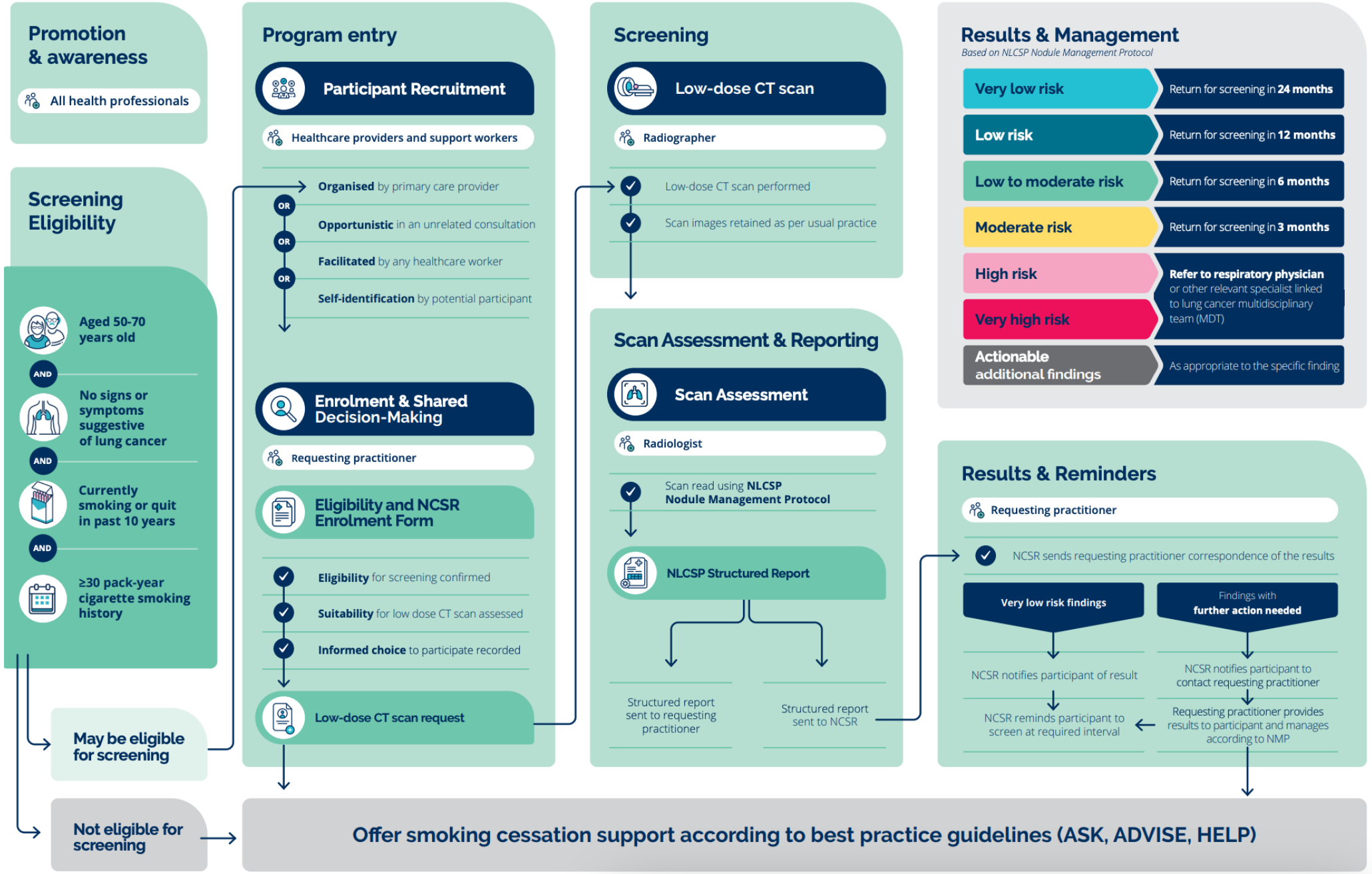
On 2 May 2023, the Minister for Health and Aged Care, the Hon Mark Butler MP, announced Government investment of $263.8 million from 2023-24 to implement a National Lung Cancer Screening Program, for commencement by July 2025.

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.

Overview of the National Lung Cancer Screening Program Pathway

Figure 1: National Lung Cancer Screening Pathway



2

How to refer and manage patients in the National Lung Cancer Screening Program

Dr Hashinee Weraduwage

HealthPathways : Clinical Management and Referral Resource

Localised Clinical Pathways
(Evidence-based guidance adapted for Melbourne clinicians)

Referral Information
(Clear referral instructions for local health services and hospitals)

Regular Updates
(Pathways reviewed and updated regularly by Clinical Editors)

CPD Hours
(Track and record CPD activities directly through Pathway page)

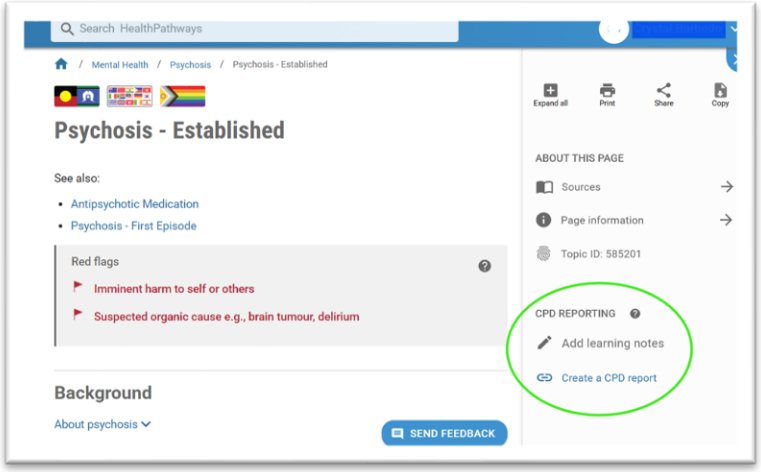
Collaborative Development
(Created by GPs, specialists, allied health and other health professionals)

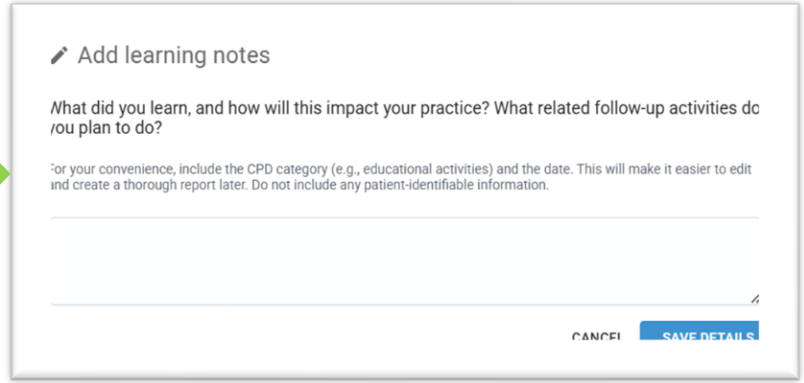
Easy Access
(Web-based platform, mobile-friendly for point-of-care use)

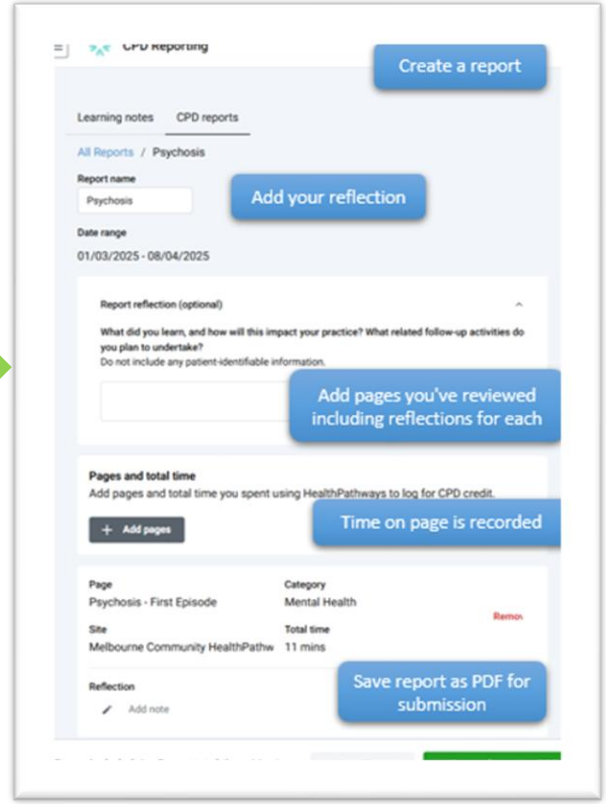
Streamlined Workflow
(Quick navigation with Assessment, Management and Referral sections all in one place)

Free for Clinicians
(No cost access for all health professionals in North Western and Eastern Melbourne PHN catchments)

Record Your CPD Today: Start with HealthPathways







Step 1: Access a Pathway Page

- Navigate to a clinical pathway (e.g., *Psychosis – Established*).
- Click **“Add learning notes”** or **“Create a CPD report”** to begin tracking your CPD activity.

Step 2: Add Learning Notes

- Reflect on what you learned and how it will impact your practice.
- Include any planned follow-up activities.
- These notes are saved to your CPD record.

Step 3: Generate Your CPD Report

- Go to the **CPD Reporting** section.
- Add reflections, review pages, and confirm time spent.
- Export your report as a **PDF for submission**.

For further information on the CPD reporting tool, please see these videos:

- How to create a CPD report
- How to add learning notes

HealthPathways Melbourne Homepage

Search bar for quickly locating clinical pathways and conditions

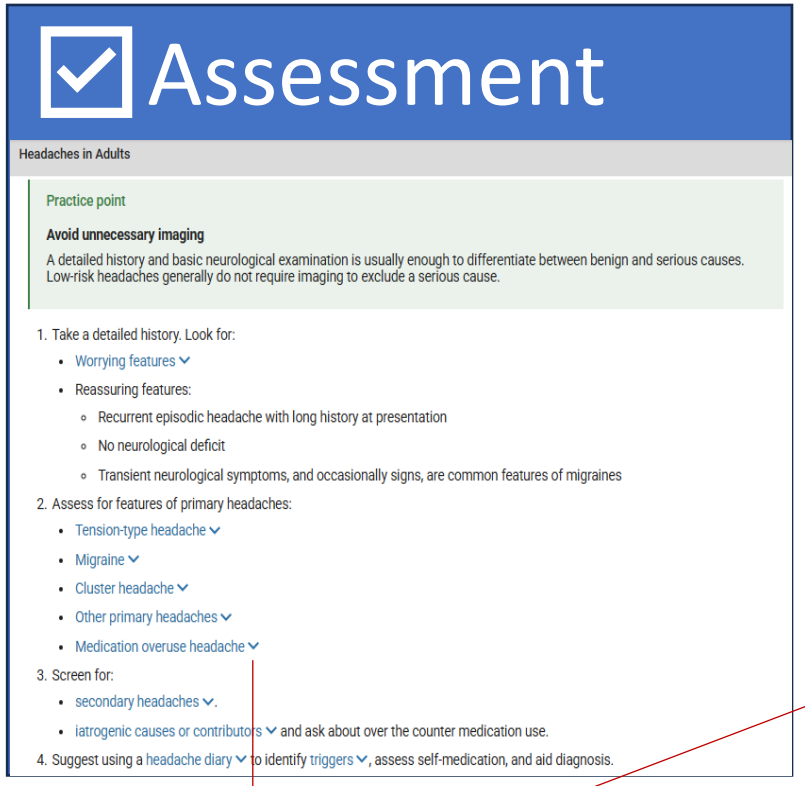
Browse clinical suites via left-hand menu, organised into easy to navigate categories

Essential quick-access links for latest updates, Pathway updates, clinical resources and MBS items

Click ‘Send Feedback’ to add comments and questions about this pathway.

Streamlined Navigation of HealthPathways for General Practice

All Sections in One Place: Assessment, Management, and Referral sections on a single page, making it easy for GPs to quickly navigate the entire clinical pathway without switching screens.



Assessment

Headaches in Adults

Practice point

Avoid unnecessary imaging

A detailed history and basic neurological examination is usually enough to differentiate between benign and serious causes. Low-risk headaches generally do not require imaging to exclude a serious cause.

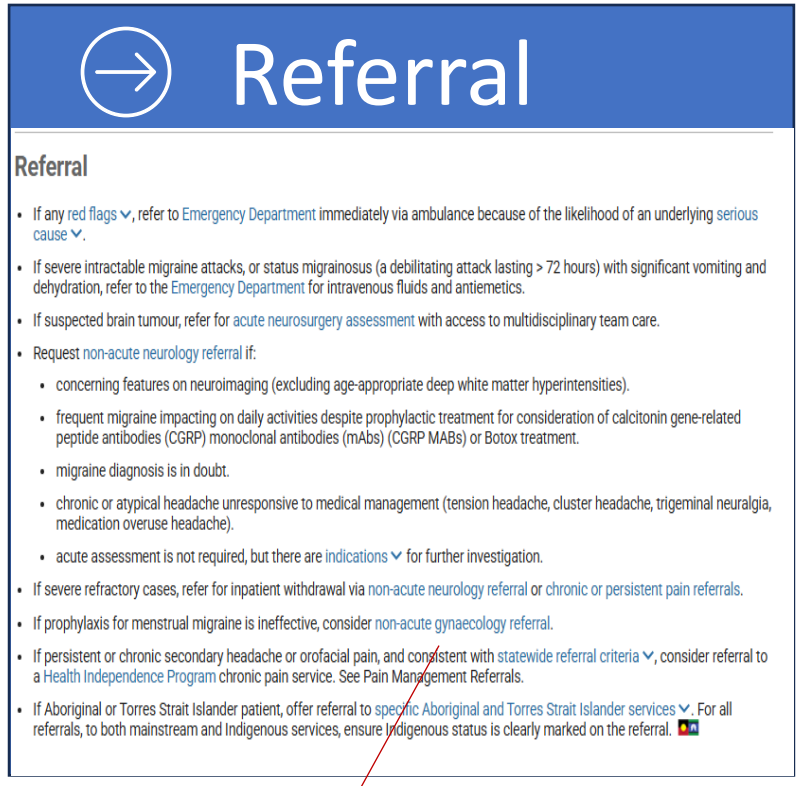
1. Take a detailed history. Look for:
   - Worrying features
   - Reassuring features:
     - Recurrent episodic headache with long history at presentation
     - No neurological deficit
     - Transient neurological symptoms, and occasionally signs, are common features of migraines
2. Assess for features of primary headaches:
   - Tension-type headache
   - Migraine
   - Cluster headache
   - Other primary headaches
   - Medication overuse headache
3. Screen for:
   - secondary headaches.
   - iatrogenic causes or contributors and ask about over the counter medication use.
4. Suggest using a headache diary to identify triggers, assess self-medication, and aid diagnosis.

Management

Headaches in Adults

Management

1. If patient identifies as Aboriginal or Torres Strait Islander, understand their specific cultural and spiritual needs when discussing and delivering treatment options, including eligibility for Integrated Team Care (ITC) services.
2. If any red flags, refer to Emergency Department immediately via ambulance because of the likelihood of an underlying serious cause.
3. If suspected brain tumour, refer to a neurosurgeon linked to a multidisciplinary team within 24 hours.
4. For all primary headaches, avoid treatment with opioids, including codeine, due to the risk of medication overuse headaches.
5. Address any patient anxiety about serious pathology. Provide reassurance and offer non-pharmacological management, including patient education.
6. If chronic headaches, monitor for depression.
7. Establish triggers for avoidance.
8. Screen for and optimise other possible contributing factors e.g., obstructive sleep apnoea, alcohol consumption, bruxism, adequate daily hydration, or optometrist review for refractive error.
9. Manage patients with primary headaches in general practice:
   - Tension-type headache management
   - Migraine management
   - Cluster headache management
   - Medication overuse headache management
10. If persistent or chronic secondary headache or orofacial pain, and consistent with statewide referral criteria, consider referral to a Health Independence Program chronic pain service. See Pain Management Referrals.
11. Provide patient pain education, as this plays a key role in management.



Referral

Referral

- If any red flags, refer to Emergency Department immediately via ambulance because of the likelihood of an underlying serious cause.
- If severe intractable migraine attacks, or status migrainosus (a debilitating attack lasting > 72 hours) with significant vomiting and dehydration, refer to the Emergency Department for intravenous fluids and antiemetics.
- If suspected brain tumour, refer for acute neurosurgery assessment with access to multidisciplinary team care.
- Request non-acute neurology referral if:
  - concerning features on neuroimaging (excluding age-appropriate deep white matter hyperintensities).
  - frequent migraine impacting on daily activities despite prophylactic treatment for consideration of calcitonin gene-related peptide antibodies (CGRP) monoclonal antibodies (mAbs) (CGRP MABs) or Botox treatment.
  - migraine diagnosis is in doubt.
  - chronic or atypical headache unresponsive to medical management (tension headache, cluster headache, trigeminal neuralgia, medication overuse headache).
  - acute assessment is not required, but there are indications for further investigation.
- If severe refractory cases, refer for inpatient withdrawal via non-acute neurology referral or chronic or persistent pain referrals.
- If prophylaxis for menstrual migraine is ineffective, consider non-acute gynaecology referral.
- If persistent or chronic secondary headache or orofacial pain, and consistent with statewide referral criteria, consider referral to a Health Independence Program chronic pain service. See Pain Management Referrals.
- If Aboriginal or Torres Strait Islander patient, offer referral to specific Aboriginal and Torres Strait Islander services. For all referrals, to both mainstream and Indigenous services, ensure Indigenous status is clearly marked on the referral.

Click to Expand

Drop-down boxes appear throughout the pathway, click them to view supplementary information.

Click on the Links

Use the interactive links to open related pathways and resources

Relevant pathways to NLCSP

Relevant Pathways

- Lung Cancer Screening
- Lung Cancer Screening Services

Other related Pathways

- Lung Cancer - Suspected
- Non-acute Respiratory Referral (> 24 hours)
- Smoking and vaping cessation

NLCSP in practice

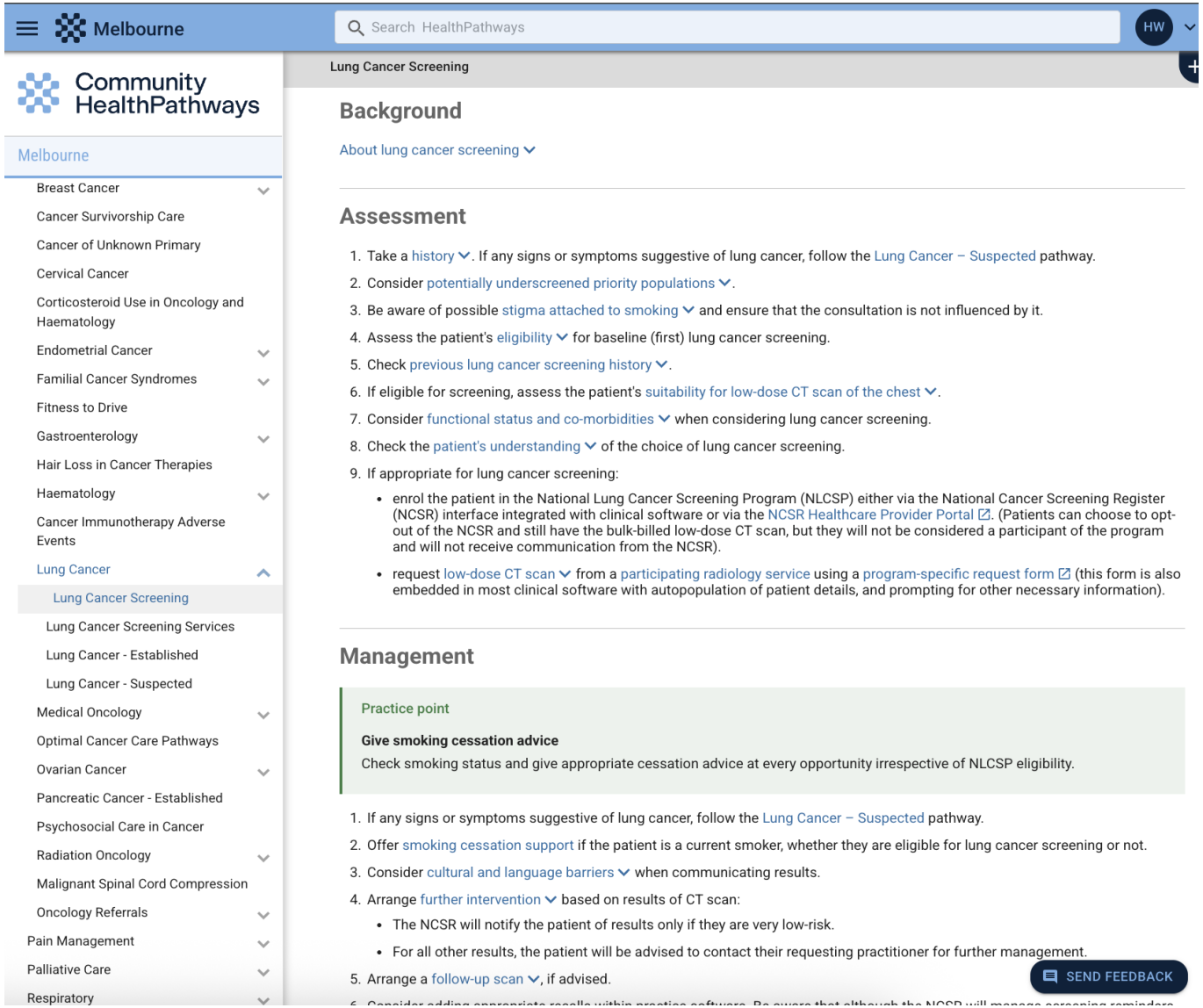
Patient finding

- **Opportunistic – during health assessments, care plans**
- **Active – smokers/ex smokers in the eligible age range**

Using the team

- Nurses
- Reception
- Practice manager

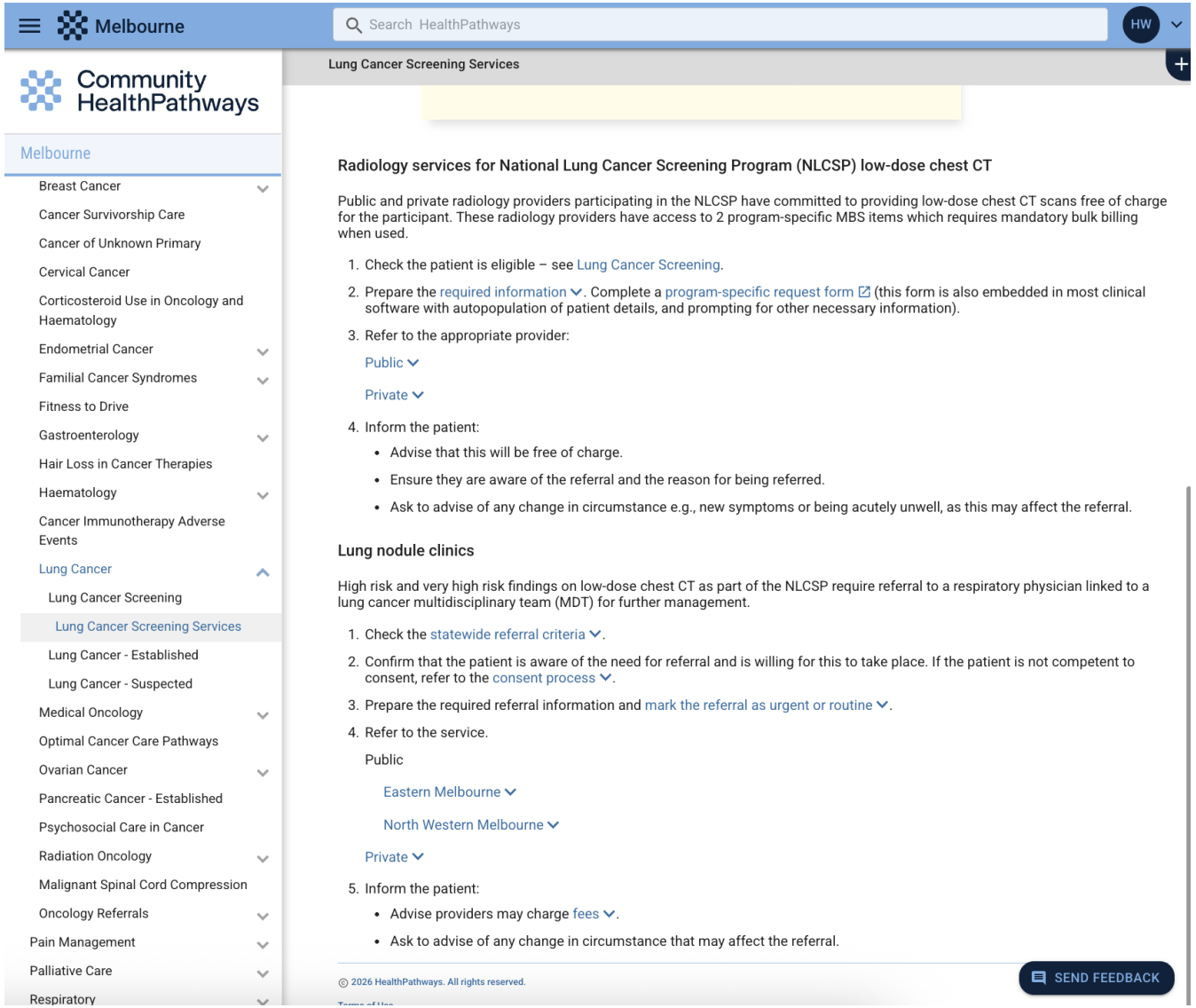
Lung Cancer Screening page



LINK:

Lung Cancer Screening pathway

Lung Cancer Screening Services page



Link:

Lung Cancer Screening services

Using clinical software – BP as an example

Integrating NCSR into clinical software

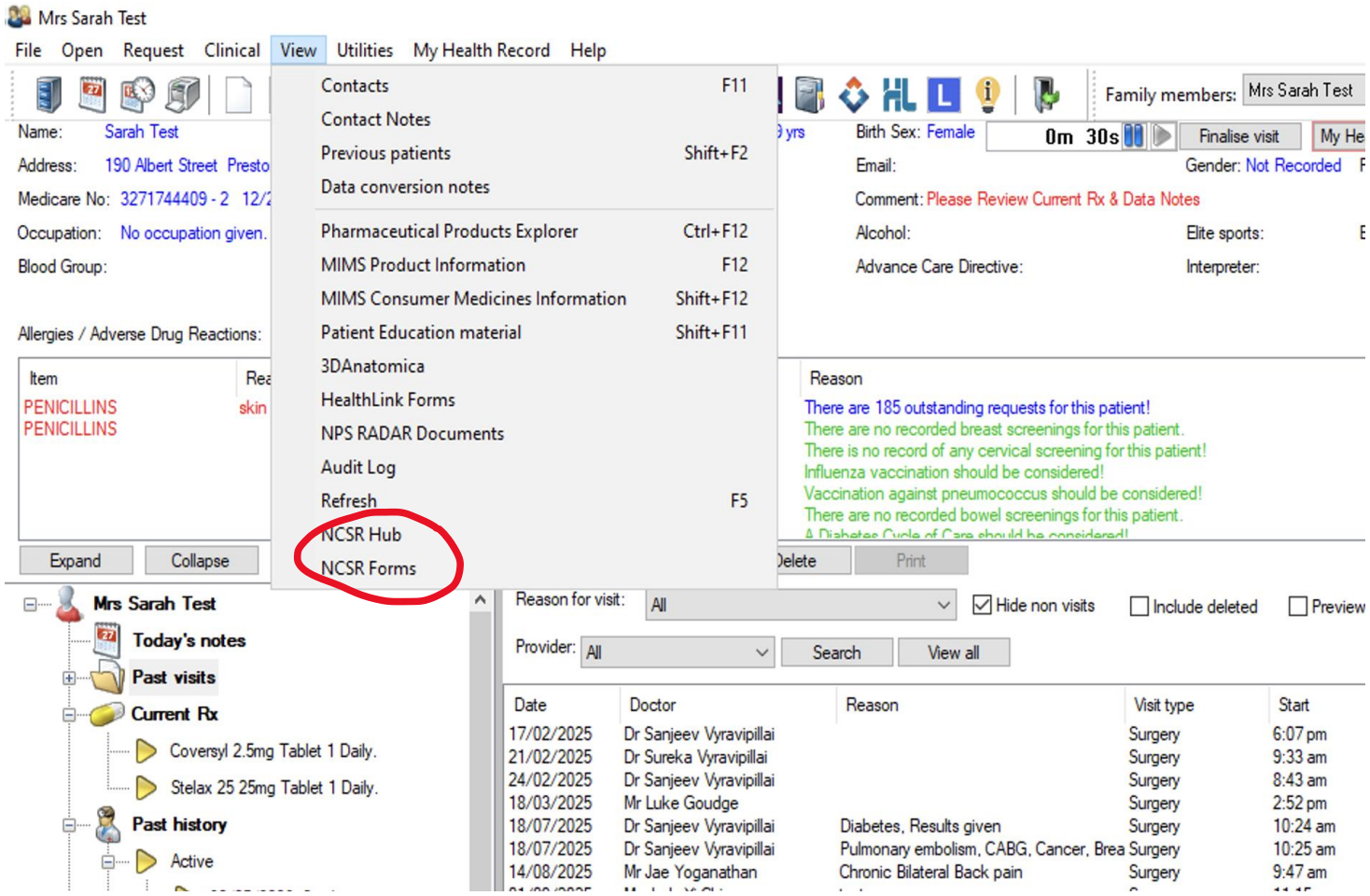
https://ncsr.gov.au/integrations

Why?

The NCSR

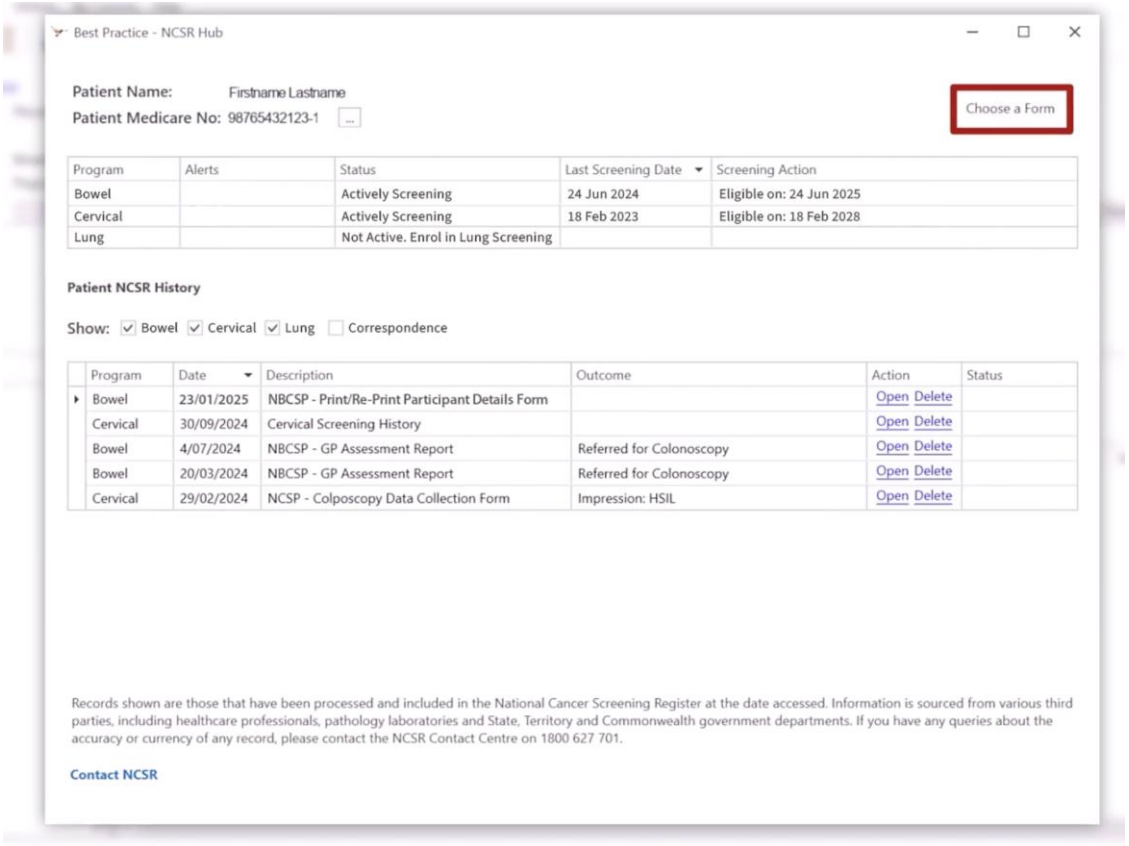
- Records low dose CT scan results (excluding images)
- Automates clinical pathways
- Sends reminders when screening or follow up is due

Accessing NCSR – to view past screening and results

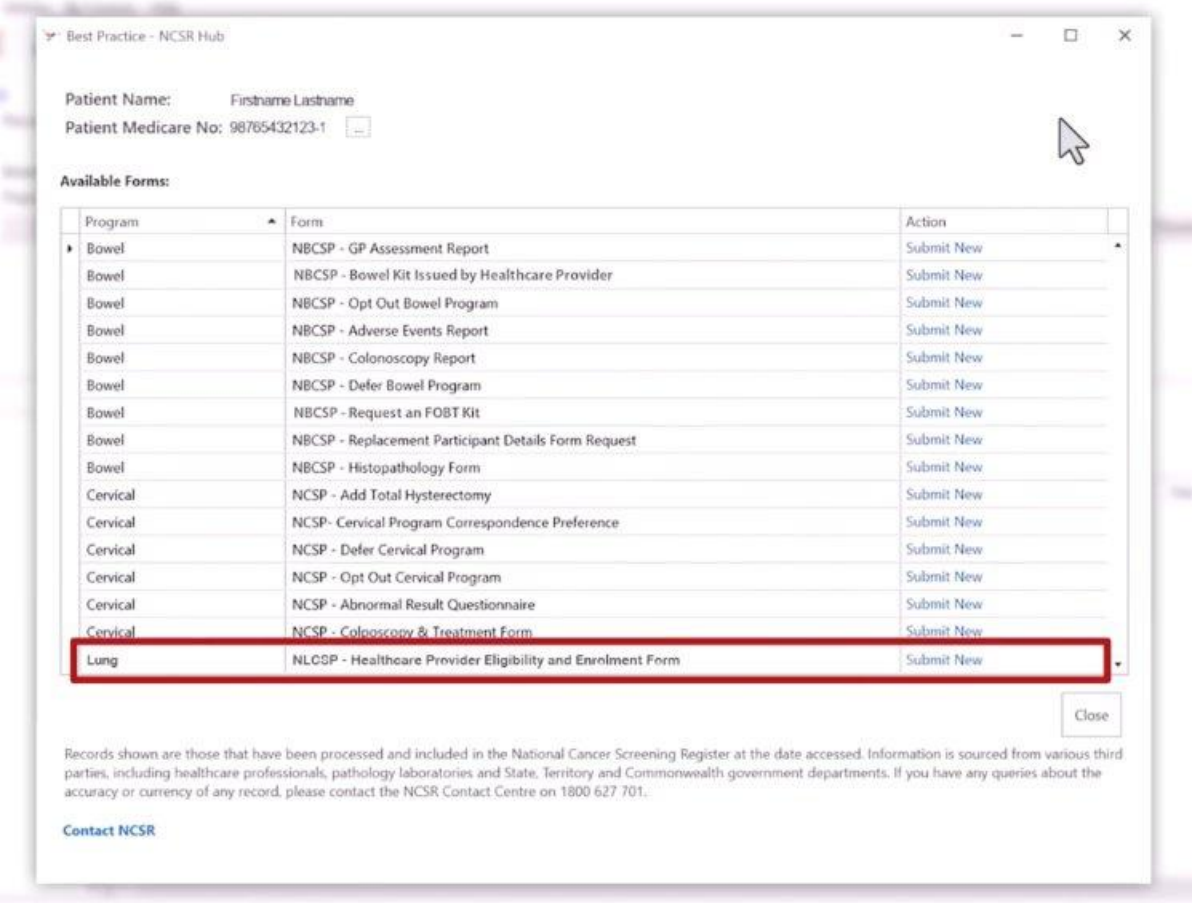


Using clinical software – BP as an example

Accessing NCSR – to view past screening and results



Healthcare Provider Eligibility and enrolment form



Using clinical software – BP as an example

Examples

Program	Alerts	Status	Last Screening Date	Screening Action
Bowel				

Patient NCSR History

Show: ☑ Bowel ☑ Cervical ☐ Correspondence

Program	Date	Description	Outcome	Action	Status
Cervical	28/04/2026	Lung Screening History		Open Delete	
Cervical	13/11/2025	NLCSP - Radiology Report	Cat 0 - Additional Findings	Open Delete	
Cervical	10/07/2025	NLCSP - Healthcare Provider Eligibility and Enrol...	Eligible - LDCT Suitable	Open Delete	

Program	Alerts	Status	Last Screening Date	Screening Action
Bowel		Overdue for Screening	15/06/2019	Eligible since 12 Jun 2021

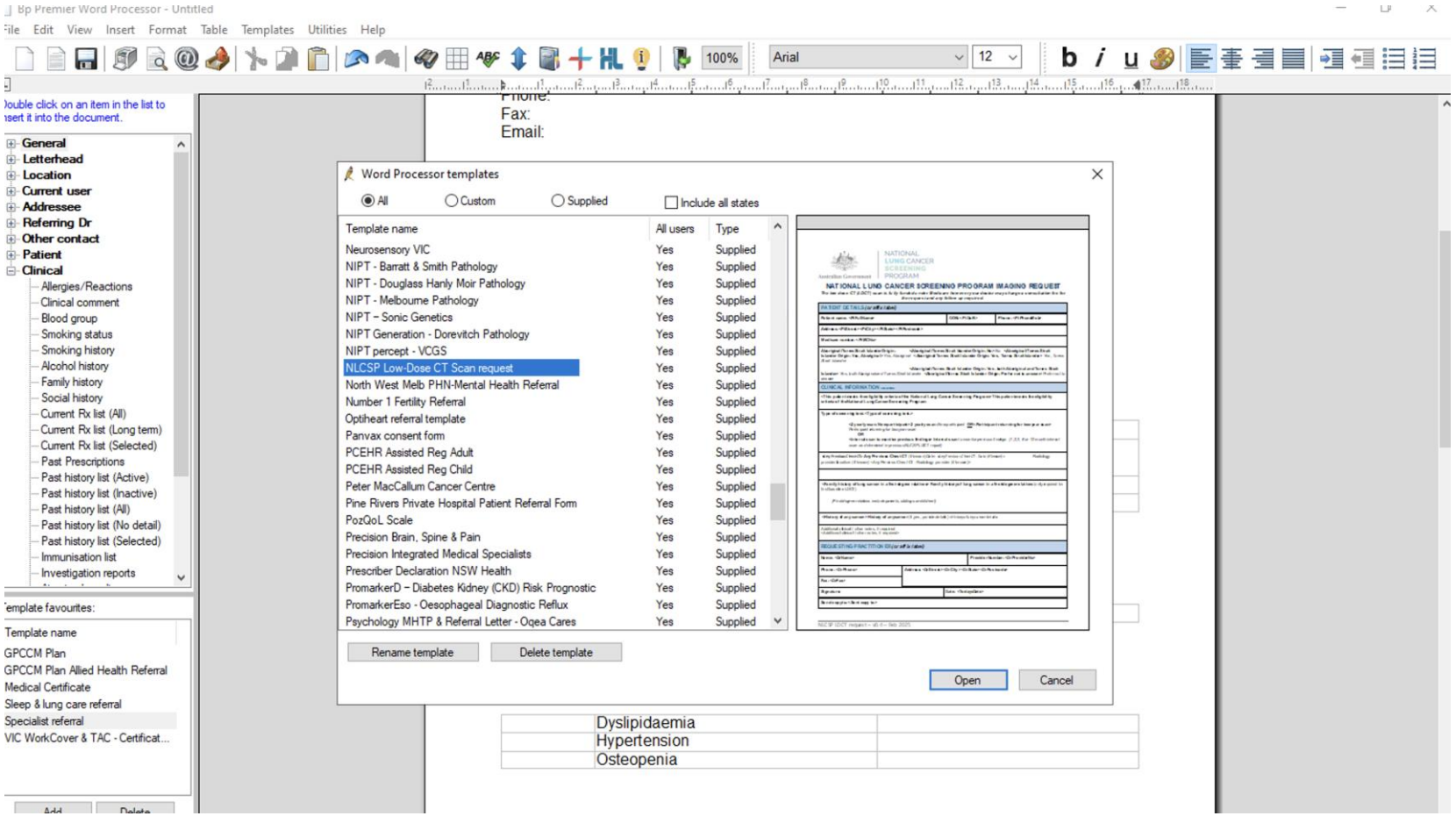
Patient NCSR History

Show: ☑ Bowel ☑ Cervical ☐ Correspondence

Program	Date	Description	Outcome	Action	Status
Cervical	28/04/2026	Lung Screening History		Open Delete	
Cervical	30/12/2025	NLCSP - Radiology Report	Cat 0 - Additional Findings	Open Delete	
Bowel	15/06/2019	NBCSP - FOBT Results and Summary	Negative	Open Delete	
Bowel	10/06/2015	NBCSP - FOBT Results and Summary	Negative	Open Delete	
Bowel	8/03/2011	NBCSP - FOBT Results and Summary	Negative	Open Delete	

Using clinical software – BP as an example

Using specific radiology forms – saved templates



Using clinical software – BP as an example

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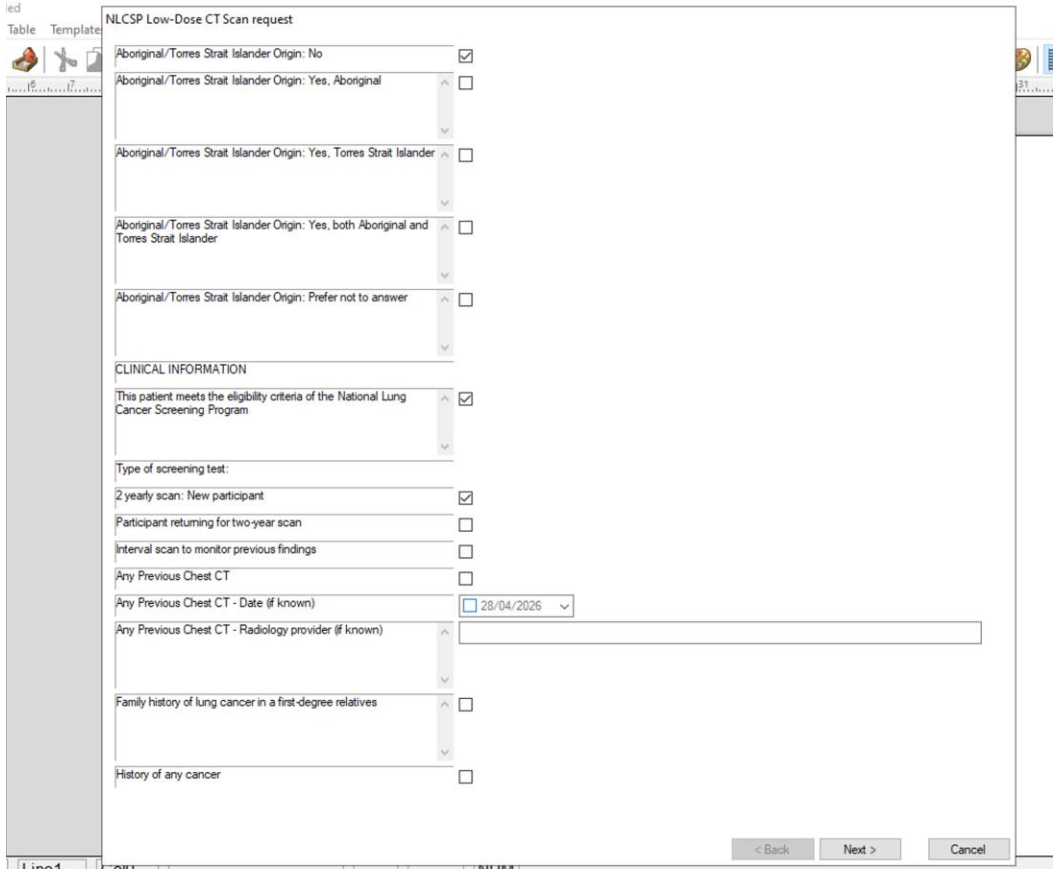

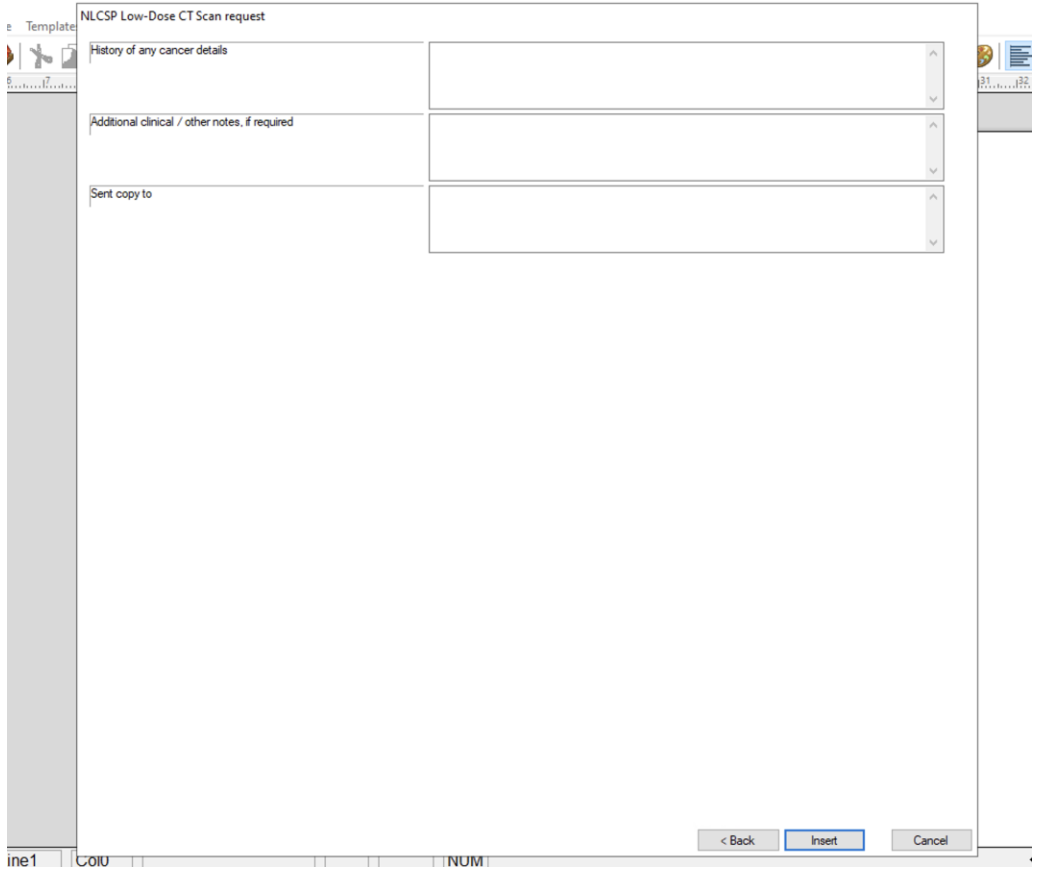

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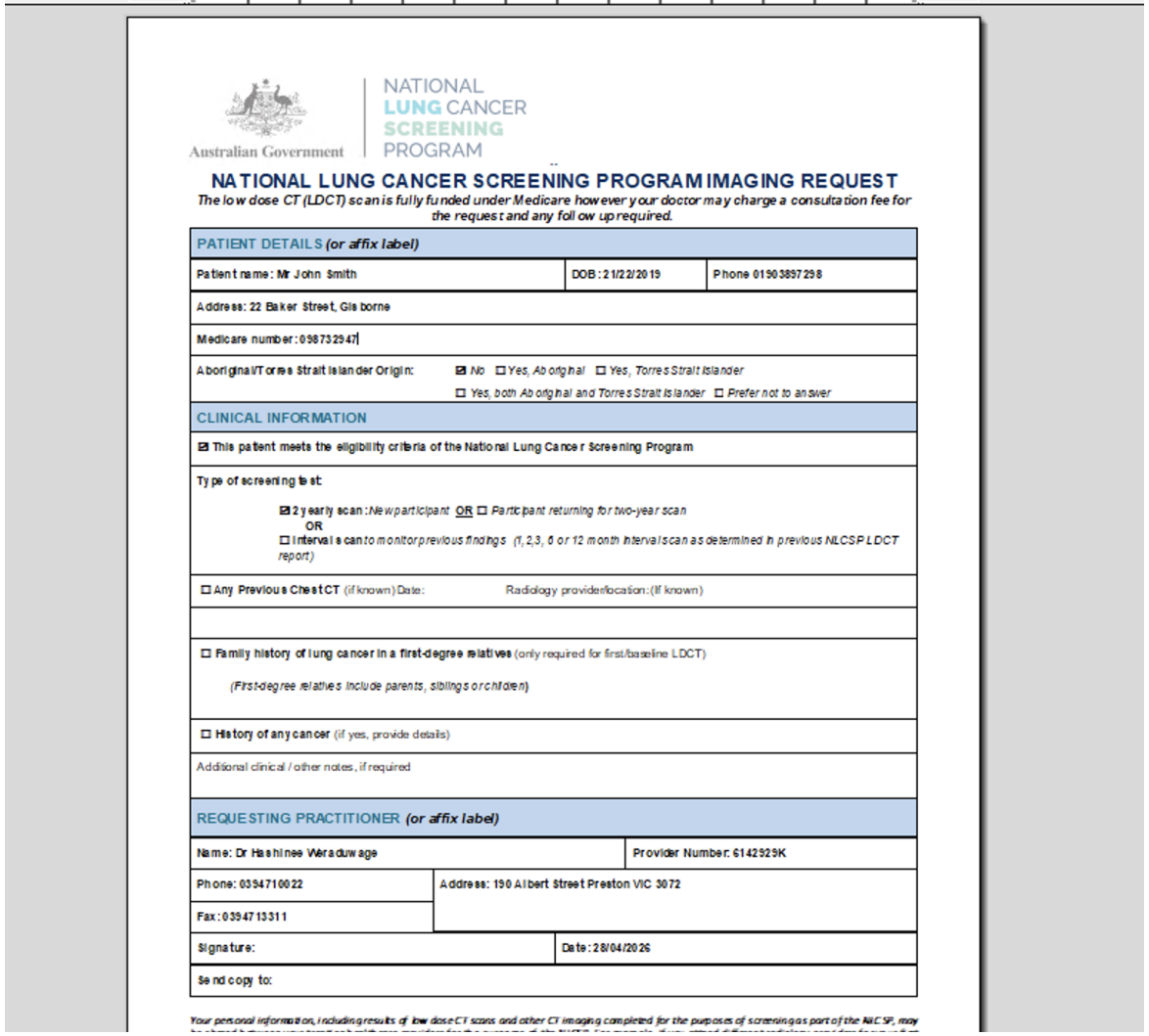


Australian Government | NATIONAL LUNG CANCER SCREENING PROGRAM

NATIONAL LUNG CANCER SCREENING PROGRAM IMAGING REQUEST

The low dose CT (LDCT) scan is fully funded under Medicare however your doctor may charge a consultation fee for the request and any follow up required.

PATIENT DETAILS *(or affix label)*		
Patient name: Mr John Smith	DOB: 21/22/2019	Phone 01903897298
Address: 22 Baker Street, Gisborne		
Medicare number: 098732947		
Aboriginal/Torres Strait Islander Origin: ☑ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Prefer not to answer		
CLINICAL INFORMATION		
☑ This patient meets the eligibility criteria of the National Lung Cancer Screening Program		
Type of screening test: ☑ 2 yearly scan: *New participant* OR ☐ *Participant returning for two-year scan* OR ☐ Interval scan *to monitor previous findings (1, 2, 3, 6 or 12 month interval scan as determined in previous NLCSP LDCT report)*		
☐ Any Previous Chest CT (if known) Date:	Radiology provider/location: (If known)	
☐ Family history of lung cancer in a first-degree relatives (only required for first/baseline LDCT) *(First-degree relatives include parents, siblings or children)*		
☐ History of any cancer (if yes, provide details)		
Additional clinical / other notes, if required		
REQUESTING PRACTITIONER *(or affix label)*		
Name: Dr Hashinee Weraduwage		Provider Number: 6142929K
Phone: 0394710022	Address: 190 Albert Street Preston VIC 3072	
Fax: 0394713311		
Signature:	Date: 28/04/2026	
Send copy to:		

Your personal information, including results of low dose CT scans and other CT imaging completed for the purposes of screening as part of the NLCSP, may

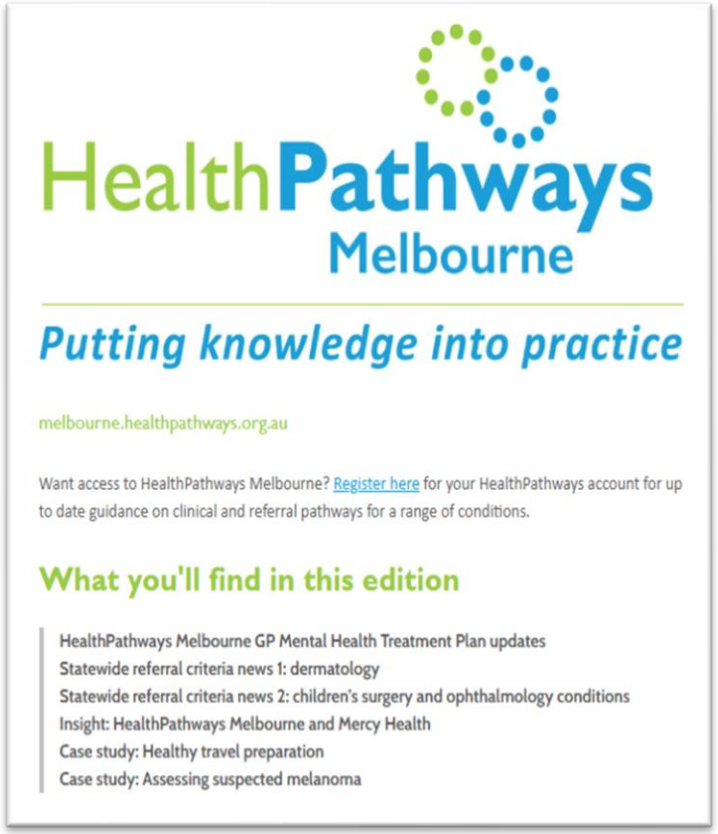
Stay Informed: Access Case Studies and Monthly Bulletin

Case Study

Real clinical scenarios for everyday GP practice

- Concise, practical case studies designed to reflect real presentation in General Practice.
- Includes management summaries, pathway links and local service consideration for quick navigation.
- Access all case studies here.

Monthly Bulletin



Monthly updates straight to your inbox

- Be the first to know about pathway updates, service changes , new case studies and employment opportunities

Subscribe to the HealthPathways Melbourne Monthly bulletin or contact us at info@healthpathwaysmelbourne.org.au

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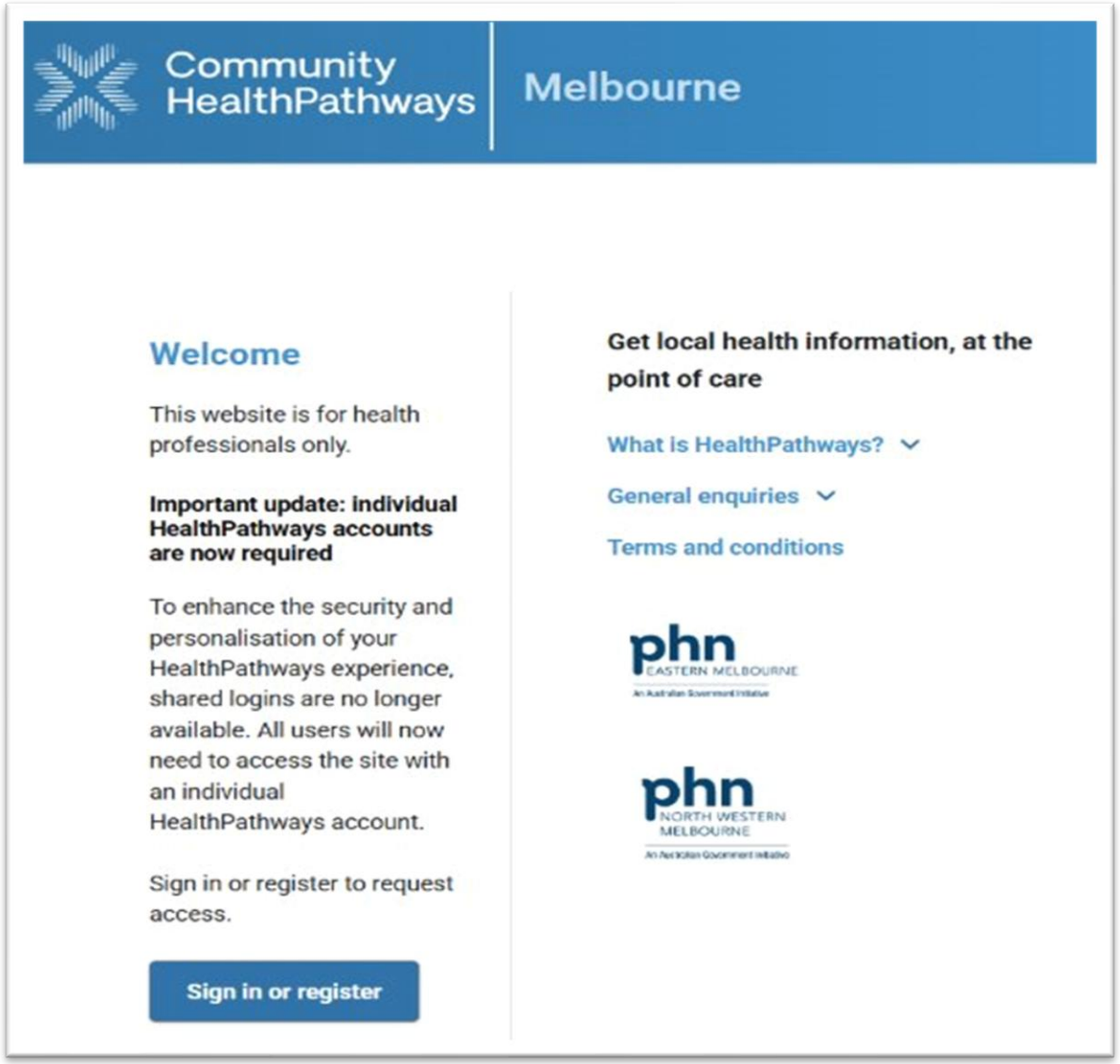
Please click on the **Sign in or register** button to create your individual account or scan the QR code below.

If you have any questions, please email the team info@healthpathwaysmelbourne.org.au



3

Smoking cessation for the patient that has tried everything

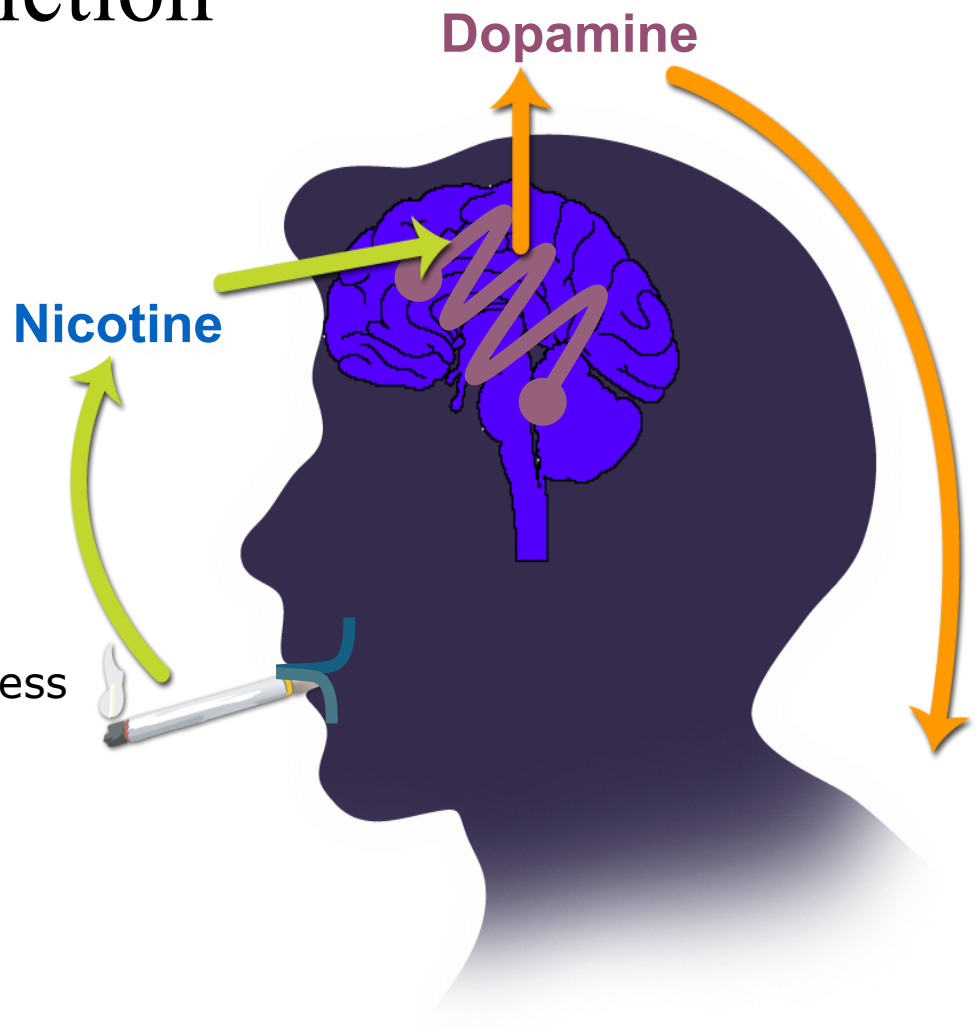
Dr Alistair Miller

With thanks to Dr Su Hii

The Cycle of Nicotine Addiction

* **Nicotine**
  - ~ 7 secs from inhalation to CNS
  - Readily crosses the BBB
  - T1/2 ~ 40 mins

* **Dopamine**
  * Pleasure & calm
  * decrease between cigarettes leads to withdrawal symptoms of irritability and stress



Jarvis. *BMJ.* 2004;328:277-279; Picciotto et al. *Nicotine Tob Res.* 1999;1:S121-S125.

Nicotine containing products

- Combustible
  - Commercial cigarettes
  - Chop-chop, Rollies
- Heated, non-combustible
  - Hookah/Shisha
  - ENDs
- Smokeless (GI cancer, oral fibrosis, leukoplakia)
  - Snus
  - Betel quid/Gundi/pan masala-
    - mixed with slacked lime (calcium hydroxide) and spices

Moist snuff

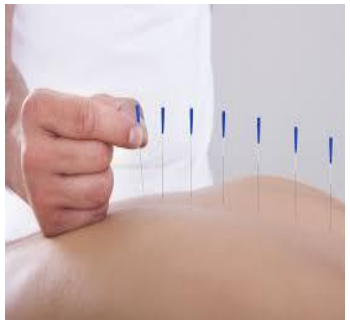
Dry snuff

Snus

Smoking cessation strategies

- “Cold turkey”
  - Ineffective in addicted individual
  - Majority will relapse within 1 week.
  - ~2.5% abstinence rate in 6 months.
- Non-pharmacological
- Pharmacotherapy

Non-Pharmacological Treatment



- Poor evidence for
  - Hypnotherapy *Abbott 2000*
  - Acupuncture *White 2006*
  - ‘cut down and quit’ *Young 2001*
  - Psychotherapy *Stead & Lancaster 2005*

- Behavioural approach *Cochrane systemic review 2021*
  - Can increase quit rates at six months or longer.
  - The evidence is strongest for counselling and guaranteed financial incentives.
  - There is no evidence of an excess of adverse events or other harms from behavioural interventions.

Behavioural strategies

- Education
- Normalise /medicalised situation
- Motivational interview
  - Express empathy
  - Developed discrepancy
  - Roll with resistance
  - Develop self efficacy
- Cue conditioning
  - Smoke free house and car, environment
  - Planning and identify high risk condition
  - Distraction
  - CBT: stress management, QUIT Victoria
- Dietary advice
  - Halve caffeine intake
  - Reduce alcohol
  - Eat breakfast, sugar hit
  - Weight gain- lifestyle modification
- Financial incentives
- Identify triggers for relapse prevention

My Quit Plan

Take a step by step approach to building your quit plan.

Create your plan

Health effects on your body

See how smoking and vaping affects your body.

See the health effects

Let's get started

I want to calculate the cost of

Smoking | Vaping | Both

I smoke

Cigarettes | Pouch tobacco | Both

How much does a pack of cigarettes cost?

$40

Each day I smoke (how many cigarettes)

20

I've been smoking for (how long)

30 | Years

60 grams of tar each year*

*Most of the tar you inhale settles on a mucus layer in your lungs. You swallow this mucus, taking cancer-causing chemicals all the way through your stomach and gut. Smoking damages your lungs' cleaning system, slowing it down. The lungs of people who smoke long-term are black with tar.

Quit smoking today and you will gain

$14,610 a year

What could you do with the extra money?

- Massage and nice lunch
- Pay off your credit card
- Night out with friends
- New bike
- Movie tickets
- Tickets to a sporting event
- New shoes
- Gym membership
- New sports gear
- Concert tickets
- Activities for the kids
- Extra groceries for the family
- Weekend away
- Family day out
- New mobile phone
- School fees

Pharmacotherapy

First line pharmacotherapy

- Combination NRT
- Varenicline
- Bupropion

Second line pharmacotherapy

- Cytisine
- Nortryptyline

NNT for abstinence @12 m

➢10 (vs 20 single NRT)

➢8

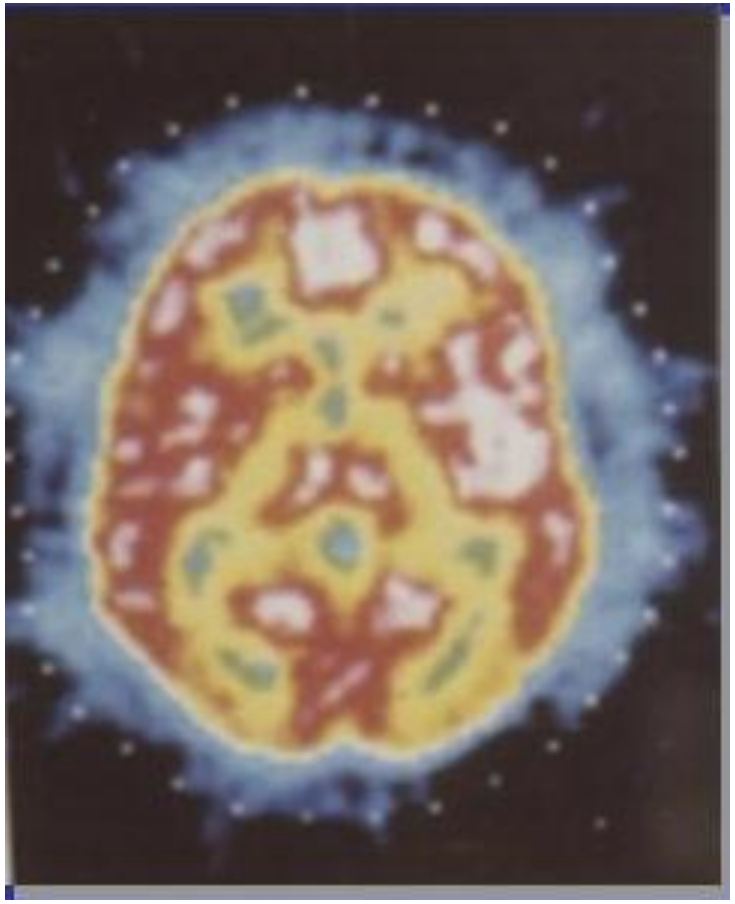
➢15

Cochrane review

Nicotine replacement therapy

NRT principles

- Adequate dosage
- Correct techniques
- Adequate duration



NRT products - Patch

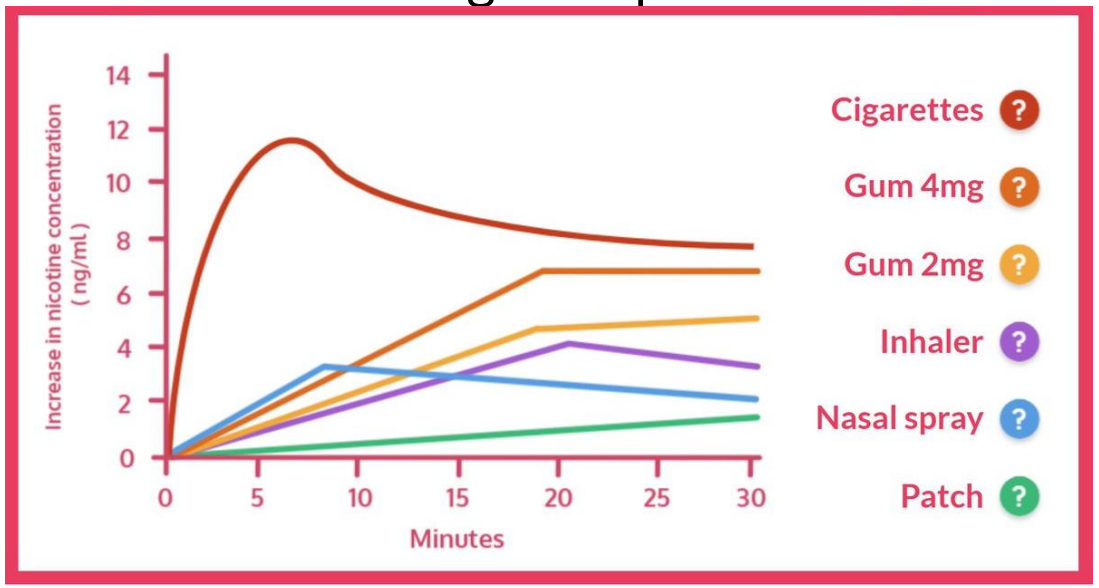
- NRT patch
  - **Slow release**
  - 7,14,21mg (21mg=10ng/ml)
  - 16 hrs patch
  - Pre-quit patch

- Advice :
  - Rotate sites
  - Preferably apply at night due to slow to achieve peak.
  - Ensure adequate duration (at least 8-12 weeks) and dose.

NRT- oral products

Principles:

- Buccal absorption
- Avoid drinking and eating ~10mins
- Faster acting than patch



Source: Balfour DJ & Fagerström KO. *Pharmacol Ther* 1996 72:51-81.

- Gum
  - 4mg, 2mg (4mg=15ng/ml), ~ 15 mins to peak
  - *Check Dentition and technique*
  - Risks of dyspepsia if excessive swallowing
- Microtabs/ spray/oral strips/lozenges
  - sublingual (2mg= 7ng/ml), ~15 mins to peak
  - Mist juice
  - Delivers ~25% more nicotine c.f NRT gum

Combination NRT therapy

- Patch provides background nicotine replacement
  - (>1 patch as required)
- Apply patches at night
    - Slow SS
    - Morning urges
    - Vivid dream vs nightmares
- Oral / inhaler NRT- for breakthrough craving
    - Inhaler and spray faster than gum

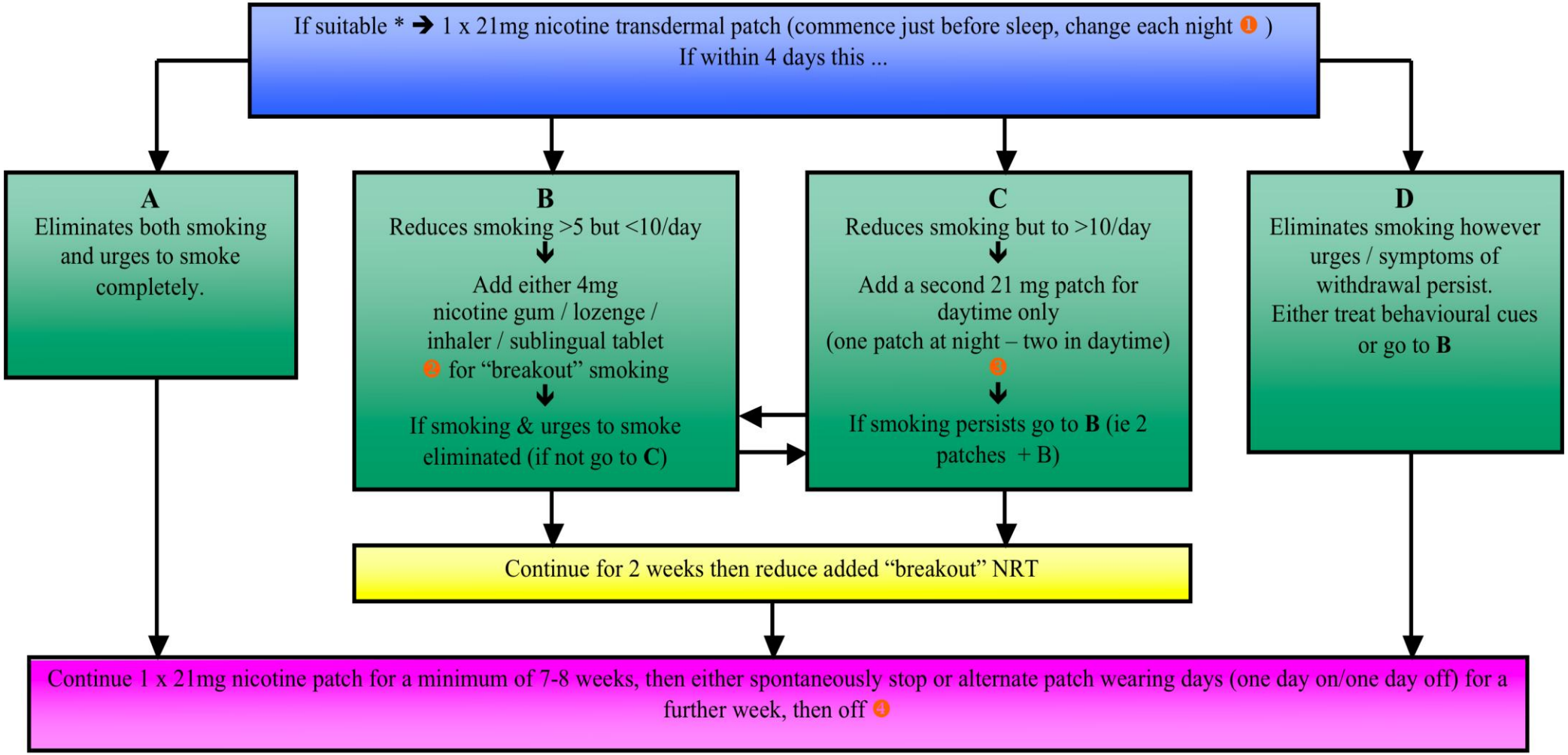
Nicotine toxicity is rare!

Optimise dose needed to prevent withdrawal Sx

Common complaints

- I have tried everything! Nothing works!
  - Ensure adequate dose, combination , technique and duration.
- The gum/ NRT makes me sick.
  - Check technique and dosing
- I am still craving.
  - Check technique and dosing
- I get itchy skin with the patch.
  - Check rotating site and use of steroid cream
- It gives me nightmare
  - Withdrawals can cause nightmare, admin timing.

Bittoun Combination Nicotine Replacement Therapy Algorithm



- KEEP IN MIND CONTRAINDICATIONS: i.e 1. **Recent cardiovascular event** (48 Hours)
  2. **Pregnancy or likelihood (all NRT OK but not patch)**

❶ Applying patch last thing before sleep allows the slow rise of nicotine overnight - the likelihood of 1st cigarette of the day "urge" is strongly diminished.

❷ Either 4mg nicotine gum or lozenge depending on patient choice. Inhaler or sublingual tablet recommended over the others if patient needs faster reinforcement.

❸ No evidence in the literature or in our experience of toxicity. Consider reducing concentrations if nausea occurs.

❹ There is no evidence in the literature for weaning (or reduction) of patch strengths.

NRT-take home messages

- Nicotine toxicity is rare (therapeutic gap)
- Failure:
  - Incorrect use/dosage
  - Inadequate treatment duration (8-10 weeks) for down-regulation of nicotine receptors
- Prescription advice, trouble shooting info

- Unfounded safety concern can be a barrier

Oral medication quit aids

Varenicline

- Safety:
  - **Nausea –must have food**
  - insomnia, abnormal dreams, headaches and flatulence.
  - Does not lower seizure threshold, little drug interaction.
  - Metallic/ash tray taste, reduces pleasure.
  - Dose reduction for renal failure.
  - No increase in neuropsychiatric adverse events. *EAGLES 2017*
- Caution:
    - Renal impairment
    - PTSD- destabilising *Campbell*
- PBS funded, streamline every 6 months
    - 4, 8,12 weeks course (ensure complete treatment).
    - Start a week before quit date

Varenicline

- Effective treatment in conjunction with behavioural therapy
- Safe in neuropsychiatric patients
  - Caution with PTSD
- Prescription advice
  - After food
  - Vivid dreams and nausea often short live (especially once stopped smoking)
- Assess CO level
- Ensure completion of treatment

Cytisine

- The world's oldest smoking cessation aid
- Derived from plant Cystisus Laburnum
- An alkaloid- α4β2 nicotinic ACH Receptor
- Discovered in 1818 and isolated in 1865
- 1912: documented as qualitatively similar to nicotine
- Smoked as cheap tobacco substitute in WW2 in eastern and western Europe
- Inspired development of Champix®

Cytisine/ Tabex®

- <u>NOT</u> TGA/FDA approved currently.

- Tabex
  - Complex schedule
  - ?? Optimal dose and duration as no human pharmacokinetic data published.
  - SE: GI - dyspepsia, dry mouth, nausea
  - CI: Pregnancy, breast feeding and uncontrolled HPT

Bupropion SR, Zyban®, Wellbutrin®

- Atypical antidepressant
  - Dual inhibitors of NA and Dopamine reuptake (NRDI).
- Similar effectiveness as NRT monotherapy, less effective than either varenicline or combination NRT.
- CI : Risk of seizure, eating disorders, MOAI, SSRI, TCA
- SE: nausea, sleep disturbances, headache.
- Principally use in patient who are not suitable for varenicline
- PBS funded
  - 150mg Daily D1-3 then BD for 12 weeks.
  - Can be used as prequit.

What about vaping?

It is now hard to support vaping as a routine smoking cessation aid

- There is data that vaping with behavioural support is effective in stopping combustible cigarettes (Hajek et al, NEJM, 2019)
- Estimates of harm reduction are made up
- Widely variable regulation worldwide
- Highly regulated in Australia with most local health bodies not advocating use

Vaping and harm in young people: umbrella review

Su Golder,[1] Greg Hartwell ,[2] Lily M Barnett,[3] Sophie G Nash,[3] Mark Petticrew,[2] Rebecca E Glover [2]

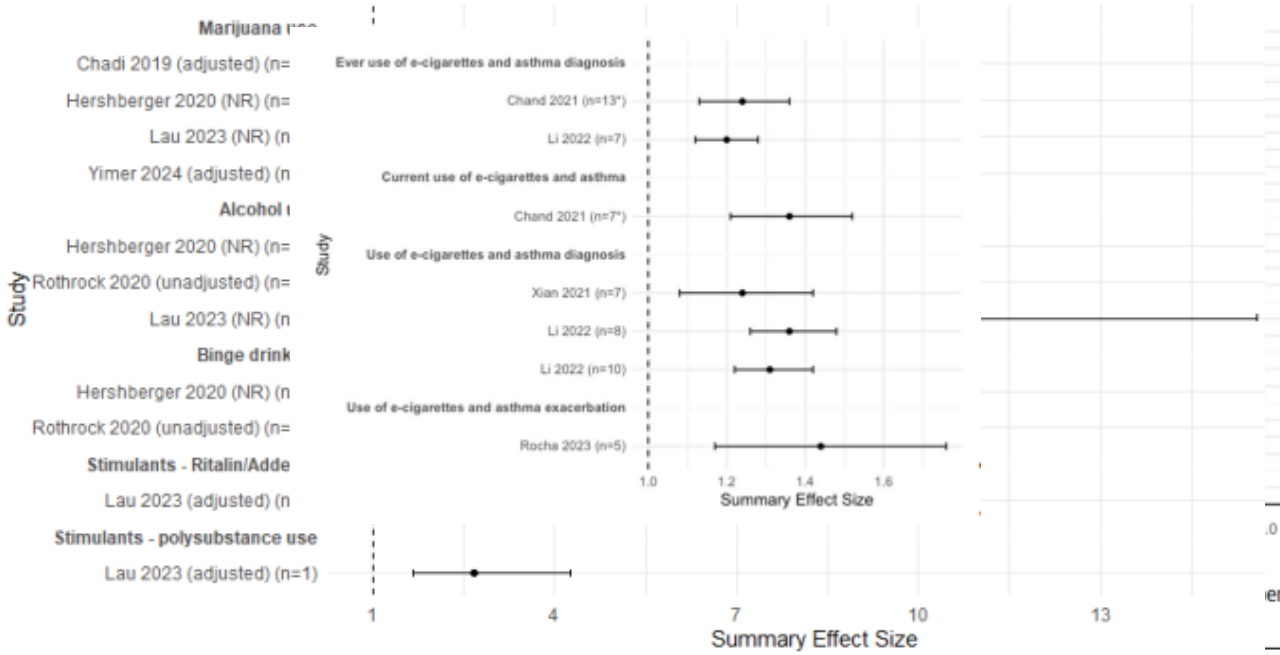
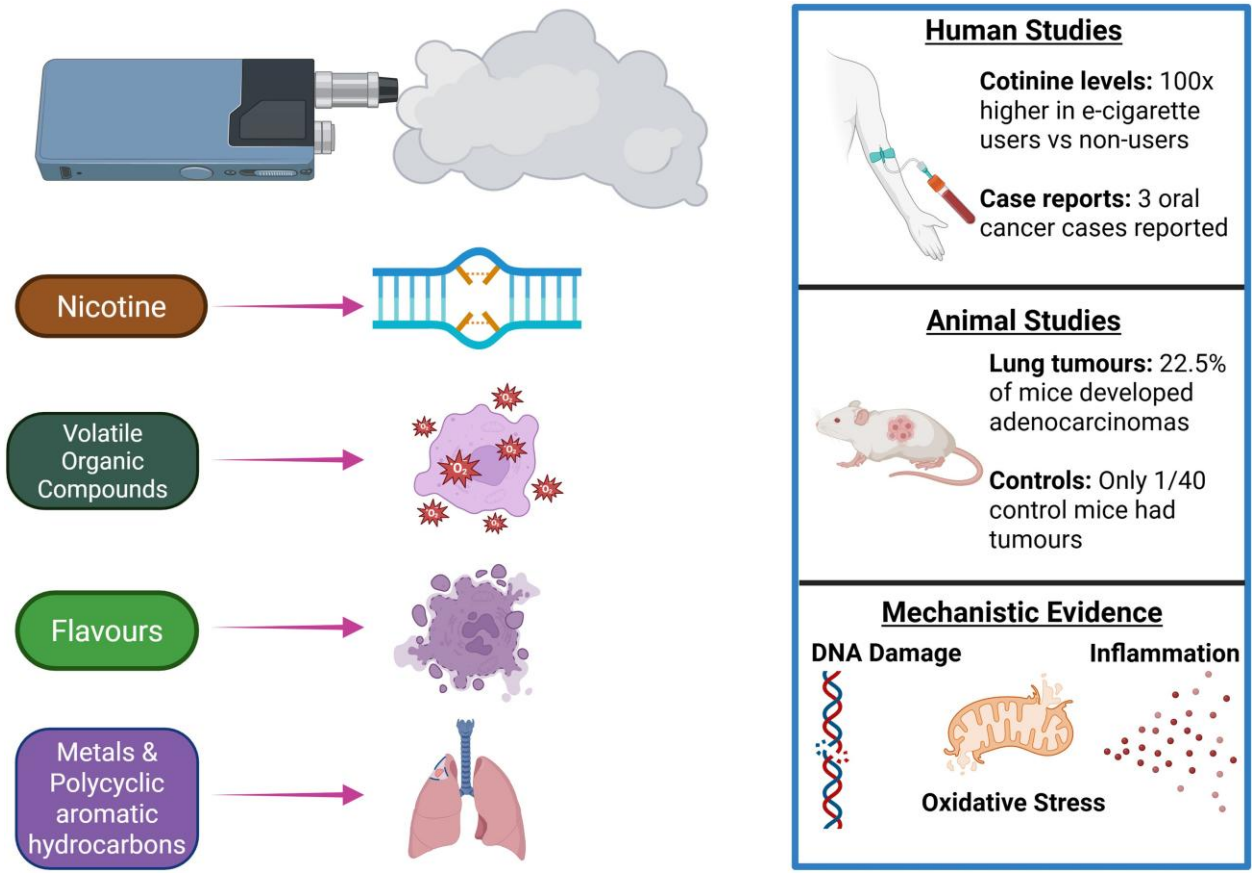


Figure 3 Forest plot for all drug initiation use and abuse, and e-cigarette use versus never use. NR = adjusted or unadjusted status of effect size was not reported.

Graphical Abstract



Carcinogenesis, Volume 47, Issue 1, 2026, bgag015, https://doi.org/10.1093/carcin/bgag015

Summary

- Engagement with behavioural support is essential regardless of
  - Opt-out Quit referral
  - Tailored action plans

- Combination NRT is safe and effective
  - Detailed prescription advice is required
  - Optimising dose and ensuring completion of course

- Varenicline remains them most effective medication available
  - Cytisine is an alternative

Post-Presentation Poll Questions

5

RMH Referral Pathways

Dr Asha Bonney

Lung nodules and cancer screening referral pathway

Pilot program and research project

Advice hotline for referrers

Referring health care providers can contact our **lung nodule and lung cancer screening nurse** advice hotline:

- call **0455 409 806**, or
- email rmhlungnoduleandscreeningreferrals@mh.org.au

Outpatient clinic referrals

We offer outpatient clinics (including telehealth) for the following conditions:

- Non-screen detected pulmonary nodules
- High-risk lung cancer screening results requiring Respiratory Physician review linked to a MDT
- Actionable respiratory additional findings detected on lung cancer screening LDCT as part of the National Lung Cancer Screening Program. Please refer to National Lung Cancer Screening Program additional findings guideline for relevant conditions.

This referral pathway **does not accept** referrals for non-respiratory additional findings detected on the lung cancer screening or additional findings detected on non-lung cancer screening LDCTs.

If further guidance is required, please contact our advice hotline on **0455 409 806** or at rmhlungnoduleandscreeningreferrals@mh.org.au.

For information about appropriate clinics, see our services and clinics list.

https://www.thermh.org.au/services/respiratory-medicine-sleep-disorders/lung-nodule-and-cancer-screening-referral-pathway

The Royal Melbourne Hospital

Questions?

Thank you for attending! What's next?

After this session you will receive:

1. *Slides, resources and the recording of this session within the week*
2. *RACGP CPD hours will be uploaded within 14 days.*
3. *Attendance certificate will be received within 4-6 weeks.*

- ***Register for more education sessions here:***
  nwmphn.org.au/resources-events/events
- ***Past education sessions can be found here:***
  nwmphn.org.au/resources-events/resources

Feedback - QR code

We welcome your feedback. Let us know if you got what you needed from this session.