Guideline Title


Bibliographic Source(s)


Guideline Status

This is the current release of the guideline.


Recommendations

Major Recommendations

The grades of recommendation (1A–2C) and the approach to rating the quality of evidence are defined at the end of the “Major Recommendations” field.

Staging of Small Cell Lung Cancer (SCLC)

In patients with SCLC (proven or suspected), a staging evaluation is recommended consisting of a medical history and physical examination, complete blood count (CBC) and comprehensive chemistry panel with renal and hepatic function tests, computed tomography (CT) of the chest and abdomen with intravenous contrast or CT scan of the chest extending through the liver and adrenal glands, magnetic resonance imaging (MRI) or CT of the brain, and bone scan (Grade 1B).

In patients with clinically limited-stage (LS)-SCLC, positron emission tomography (PET) imaging is suggested (Grade 2C).

Remark: If PET is obtained, then bone scan may be omitted.

In patients with SCLC, it is recommended that both the Veterans Administration system (LS vs extensive-stage [ES]) and the American Joint Committee on Cancer/International Union Against Cancer seventh edition tumor, node, metastasis (TNM) system should be used to classify the tumor stage (Grade 1B).

Role of Surgery
In patients with clinical stage I SCLC, who are being considered for curative intent surgical resection, invasive mediastinal staging and extrathoracic imaging (head MRI/CT and PET or abdominal CT plus bone scan) is recommended (Grade 1B).

In patients with clinical stage I SCLC after a thorough distant and invasive mediastinal stage evaluation, surgical resection is suggested over nonsurgical treatment (Grade 2C).

In patients with stage I SCLC who have undergone curative-intent surgical resection, platinum-based adjuvant chemotherapy is recommended (Grade 2C).

**Use of Radiation Therapy (RT) for SCLC**

In patients with LS-SCLC, early chemoradiotherapy, with accelerated hyper-fractionated radiation therapy (twice-daily treatment) concurrently with platinum-based chemotherapy, is recommended (Grade 1B).

In patients with LS- or ES-SCLC who achieve a complete or partial response to initial therapy, prophylactic cranial irradiation (PCI) is recommended (Grade 1B).

*Remark:* The regimen of 25 Gy in 10 daily fractions has the greatest supporting data for safety and efficacy.

In patients with ES-SCLC who have completed chemotherapy and achieved a complete response (CR) outside the chest and complete or partial response in the chest, a course of consolidative thoracic radiotherapy (TRT) is suggested (Grade 2C).

**Novel Therapies**

In patients with either LS or ES-SCLC, four to six cycles of platinum-based chemotherapy with either cisplatin or carboplatin plus either etoposide or irinotecan is recommended over other chemotherapy regimens (Grade 1A).

**Second-line Treatment of SCLC**

In patients with relapsed or refractory SCLC, the administration of second-line, single-agent chemotherapy is recommended (Grade 1B).

*Remark:* Reinitiation of the previously administered first-line chemotherapy regimen is recommended in patients who relapse >6 months from completion of initial chemotherapy. Enrollment in a clinical trial is encouraged.

**Treatment of SCLC in the Elderly**

In elderly patients with LS-SCLC and good performance status (PS) (Eastern Cooperative Oncology Group [ECOG] 0-2), treatment with platinum-based chemotherapy plus TRT is suggested, with close attention to management of treatment-related toxicity (Grade 2B).

In elderly patients with ES-SCLC and good PS (ECOG 0-2), treatment with carboplatin-based chemotherapy is suggested (Grade 2A).

In elderly patients with SCLC and poor PS, treatment with chemotherapy is suggested if the poor PS is due to SCLC (Grade 2C).

**Definitions:**

Strength of the Recommendations Grading System

<table>
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<td>Uncertainty in the estimates of benefits, risks, and burden; benefits, risk, and burden may be closely balanced</td>
<td>Evidence for at least one critical outcome from observational studies, case series, or RCTs, with serious flaws or indirect evidence</td>
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**Clinical Algorithm(s)**

None provided

**Scope**

**Disease/Condition(s)**

Small cell lung cancer (SCLC)

**Guideline Category**

Evaluation
Management
Treatment

**Clinical Specialty**

Family Practice
Internal Medicine
Oncology
Pulmonary Medicine
Radiation Oncology
Thoracic Surgery

**Intended Users**
**Guideline Objective(s)**

- To inform the clinical decisions that must be jointly made by physicians and patients in developing diagnostic, treatment, and management plans so that they can enhance the benefits and reduce the harms associated with various options
- To revise the evidence-based guidelines on staging and best available treatment options for small cell lung cancer (SCLC)

**Target Population**

Patients with small cell lung cancer (SCLC)

**Interventions and Practices Considered**

**Evaluation**

1. Medical history and physical examination
2. Complete blood count (CBC)
3. Comprehensive chemistry panel with renal and hepatic function tests
4. Computed tomography (CT) scan (chest and abdomen)
5. CT scan or magnetic resonance imaging (MRI) of the brain
6. Bone scan
7. Staging according to Veterans Administration system and American Joint Committee on Cancer/International Union Against Cancer staging by tumor, node, metastasis (TNM)

**Management/Treatment**

1. Invasive mediastinal staging and extrathoracic imaging (head CT/MRI plus either whole-body positron emission tomography [PET] or abdominal CT plus bone scan) prior to surgery
2. Surgical resection
3. Platinum-based adjuvant chemotherapy (cisplatin or carboplatin plus either etoposide or irinotecan)
4. Accelerated hyperfractionated radiation therapy concurrently with platinum-based chemotherapy for patients with limited-stage (LS) small cell lung cancer (SCLC)
5. Prophylactic cranial irradiation (PCI)
6. Consolidative thoracic radiotherapy (TRT) for patients with extensive-stage (ES)-SCLC
7. Single-agent chemotherapy for patients with relapsed or refractory SCLC
8. Management of elderly patients based on performance status

**Major Outcomes Considered**

- Poor performance status (PS)
Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

To identify relevant studies, a team of research librarians and authors conducted a comprehensive literature search using small cell lung cancer (SCLC) terms and an adapted therapy hedge from MEDLINE's Clinical Queries, optimized for sensitivity. The search was conducted in MEDLINE, EMBASE, and five Cochrane databases (Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, Cochrane Central Register of Controlled Trials, Health Technology Assessment, and NHS Economic Evaluation Database). Results were limited to human and English-language abstracts and articles published from 2004 to 2011. The search done for the 2007 guidelines was through March 2005, so this current search overlapped the previous guidelines search by approximately 1 year. The search strategy and results are available on request. The search was structured around the following patient, intervention, comparator, outcome (PICO) questions:

1. In patients with SCLC, what is the ability of positron emission tomography (PET) imaging to determine the stage of cancer?
2. In patients with limited-stage (LS)-SCLC, how do the parameters of thoracic radiotherapy (TRT) affect survival?
3. In patients with extensive-stage (ES)-SCLC, what is the survival after treatment with chemotherapy, including novel and targeted agents?
4. In elderly patients with SCLC, what is the survival and toxicity after treatment with chemotherapy or radiation?

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Rating Scheme for the Strength of the Evidence

Not stated

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Assessment of Study Quality

Systematic reviews and meta-analyses were assessed using Documentation and Appraisal Review Tool (DART) (R. L. Diekemper; B. K. Ireland, MD; and L. R. Merz, PhD, MPH, DART, unpublished data, 2012), which was developed as an improved alternative to the existing tools for use in a clinical setting. However, this tool has been adopted for use in American College of Chest Physicians (ACCP) guidelines and consensus statements since 2011.
Quality was assessed for each study as well as for the body of relevant evidence. Based on the population, intervention, comparator, and outcome (PICO) questions and volume of available literature, multiple study designs were included in the systematic reviews of the literature. Randomized controlled trials (RCTs) primarily indicate benefits, but whenever observational studies met inclusion criteria they were often helpful in identifying harms. Observational studies were also examined when RCTs were not available to answer a particular PICO question. Allowing for multiple study designs resulted in the need for multiple quality assessment tools. Tools were chosen for assessing RCTs, observational studies, and diagnostic studies. The quality assessment tool for RCTs (R. L. Diekemper, B. K. Ireland, and L. R. Merz, unpublished data, 2012) was used for assessing the quality of RCTs, and a tool developed by the committee of the ninth edition of the Antithrombotics Guidelines was used for assessing the quality of observational studies. Diagnostic studies were assessed using the Quality Assessment Tool for Diagnostic Accuracy Studies (QUADAS).

Meta-analyses

If a recently published good-quality meta-analysis was available, then it was used to inform the recommendations. When a good-quality meta-analysis was not available, guideline authors were encouraged to perform their own meta-analyses. Meta-analyses were performed when the data were fairly homogeneous. If a study was deemed poor quality, then it was not included in the pooled analysis. Heterogeneity of the pooled results was assessed using a \( \chi^2 \) test and Higgins \( I^2 \), and a forest plot was examined for consistency of the results. The random effects model was chosen a priori as the appropriate model for pooling the data because it accounts for heterogeneity among the included studies. Results from the meta-analyses are available in the supplementary materials that can be downloaded from the Journal website under the corresponding article in the table of contents.

Methods Used to Formulate the Recommendations

Description of Methods Used to Formulate the Recommendations

Panel Composition and Responsibilities

A call for applications to serve on the 3rd edition of the American College of Chest Physicians (ACCP) Lung Cancer Guidelines (LC III) panel was put forth to the ACCP membership, to past panelists, and to other organizations that have previously endorsed earlier editions of these guidelines or appointed representatives to serve on those panels. Guiding the team was the LC III Executive Committee, composed of a Panel Chair, Vice Chair, Liaison to the Guidelines Oversight Committee (GOC), and two staff members, one serving as an adviser and the other as the lead methodologist. The GOC appointed the Liaison and the Chair, who was required to be free of conflicts of interest (COI). This Executive Committee provided general oversight and guidance; multiple reviews of research questions, article outlines, manuscripts, evidence tables, and other supporting documents; and facilitation of the final conference discussions and voting. As the scope was defined, content experts in each major area were identified to serve as topic editors and nominated by the Panel Chair to be advanced to the GOC for the requisite qualifications and COI review and approval process. These topic editors organized their research and writing teams, oversaw the work of the individual members, edited separate contributions into synthesized manuscripts, presented evidence at the final conference, and managed any of their committee members who were approved with management stipulations relevant to their COIs.

Each topic editor was initially charged with proposing individuals to support their topic committees with expertise in the content area and/or methodology. With the Chair's approval, these individuals were nominated for GOC reviews for COI and expertise. In some cases, GOC staff helped to locate additional methodologic support when it was determined to be necessary for various article committees. This resulted in an international panel of >100 multidisciplinary experts across 24 articles representing the fields of pulmonary medicine, critical care medicine, thoracic surgery, medical and radiation oncology, pathology, integrative medicine, primary care, health-care research, guidelines methodology, and epidemiology. Nineteen international organizations that are also dedicated to advancing research and practice in the area of lung cancer were invited to appoint representatives to this guideline project as adjunct participants. These individuals, unless already approved panelists, were not considered full voting members of the panel, since they had not been through the same ACCP COI review, but were included at the final conference, participated fully in the discussions, and provided external review and feedback on the manuscripts and supporting documentation.

Formulating the Recommendations

In most cases the topic editors, along with the other completely non-conflicted members of the article committee, formulated the recommendations. The summarized evidence tables and profiles (where profiles existed) provided the foundation for the recommendations. In formulating the recommendations, panelists considered not only the body of evidence but also the balance between the benefits and harms and considerations of
other factors, such as cost or resource availability considerations and patient values and preferences, which might vary widely for some recommendations. These additional considerations are described in a Remarks section, which appears just below the relevant recommendation in the publication, each time the recommendation appears.

Grading the Recommendations

Recommendations that are strong must be differentiated from those that are weak or weaker. Thus, the ACCP Grading System was used (see the "Rating Scheme for the Strength of the Recommendations" field), and the wording of the recommendations is explicit. This grading system has been used since 2005 and is based on two dimensions: the balance of benefits to harms and the quality of the evidence base. If the benefits clearly outweigh the harms or the harms clearly outweigh the benefits, the strength of the recommendation is considered strong and graded as a 1. In most cases, when there is strong confidence that the benefits outweigh the harms, most patients would choose the intervention endorsed in that recommendation. However, when the tradeoffs between desirable and undesirable consequences are not as clear, variability in patient preferences and values often becomes germane to the decision-making conversation.

Weak recommendations are those for which the benefits and harms are more equally balanced, and thus a clear choice is not as obvious; these are graded with a 2. Strong recommendations are phrased, "the panel recommends," whereas weak recommendations are phrased "the panel suggests." Accompanying these indications of the strength of a recommendation is a letter score (A, B, or C) representing the grading of the body of relevant literature.

In grading the quality of the evidence, RCTs start with a high score but might be downgraded to moderate or even low based on the following criteria: limitations in the study design or conduct of the trial, imprecision, indirectness relative to the specifics of the PICO question, inconsistency in the results, and risk of reporting bias. Observational studies, on the other hand, start off as low-level evidence but can be upgraded to moderate or even high if exceptionally large and consistent treatment effects increase confidence in the findings, especially if there is a strong dose-response gradient.

The final grades are combinations reflecting the strength of the recommendation and the quality of the evidence. Strong recommendations with high quality evidence, grade of 1A, are less common than in past editions of these guidelines, since the evidence is assessed with greater rigor for most topics, and few studies without important limitations are available.

However, recommendations that do attain this score are those for which the panel could state with confidence that new studies would be unlikely to change the direction of the effect. These recommendations apply to most patients in most circumstances. But as the grades decline, patient values and preferences likely would play an increasingly greater role in determining the best treatments or interventions for each patient.

The Final Conference

As the evidence reviews were completed and the tables and profiles prepared, the manuscripts and recommendations were drafted. Members of the article committees convened by phone or e-mail to discuss the evidence and work on drafting and grading the recommendations. These discussions generally resulted in agreement on both the quality of the evidence and strength of the recommendations.

The manuscripts and supporting tables were then reviewed by members of the Executive Committee and, after several iterations, the revised versions were shared among all panelists and the representatives of invited organizations in advance of the conference. The other panelists and representatives were asked not only to provide feedback but also to review the recommendations to identify any controversies. A recommendation was deemed to be controversial if at least one person disagreed with the wording or the grading, if there was controversy in practice, if there were wide variations in practice, or if at least one person asked that it be discussed among the broader panel and association representatives. These identified controversies composed the main agenda for the conference.

See the "Methodology for Development of Guidelines for Lung Cancer" (see the "Availability of Companion Documents" field) for more information.

Rating Scheme for the Strength of the Recommendations

Strength of the Recommendations Grading System

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**Cost Analysis**

American College of Chest Physicians (ACCP) guidelines include consideration of resources in recommendations under selected circumstances. If it is likely that resource considerations would impact the direction or strength of a recommendation, a search for cost-effectiveness studies may have been conducted. Most recommendations in these guidelines do not include a full assessment of resource considerations. However, they can be adapted to middle- and low-income countries using the ADAPTE strategies.

**Method of Guideline Validation**

External Peer Review

Internal Peer Review

**Description of Method of Guideline Validation**

Internal and External Peer Review

Once Executive Committee approval was received, the articles were submitted to American College of Chest Physicians (ACCP) staff for several layers of review. All reviewers were required to undergo a full conflict of interest (COI) appraisal before being approved. In the first round of reviews, the Thoracic Oncology NetWork reviewed the content of the manuscripts and the members of the Guidelines Oversight Committee (GOC) assessed the manuscripts for adherence to the methodology and conformance with the evidence. The ACCP President also appointed members of the Board of Regents to evaluate the guidelines in depth. All comments were collated into spreadsheets to ensure that they were appropriately answered. GOC and board reviewers discussed each comment and determined which should be mandatory for the authors to amend and which were provided as suggestions for improvement. All reviews and comments were anonymous, and authors were required to respond to all mandatory issues either by revising the manuscripts or providing written justification explaining why they did not agree with the
The revised manuscripts were submitted for round II review, simultaneously with the Journal peer review. Once the GOC and board reviewers approved the manuscripts, the ACCP President, President Elect, President Elect Designee, and Immediate Past President reviewed the guidelines. Approval was granted pending confirmation from the Board of Regents, before submission to the journal for final review by the Journal Editor. In addition to this extensive review process, which included nearly 30 individual reviewers from the ACCP leadership, external organizations were provided with opportunities to provide feedback before, during, and just after the conference. This final version was submitted for consideration for endorsement to all of the invited organizations, whether or not they sent representatives to the conference. However, once the guidelines were approved by the ACCP Board of Regents, no further changes were accepted. Organizations that provided endorsements are listed in each article.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate treatment of patients with small cell lung cancer (SCLC)

Potential Harms

- In one study, prophylactic cranial irradiation (PCI) had side effects but did not have a clinically significant effect on global health status. The largest mean difference between the two arms was observed in fatigue and hair loss, which were greater in those who received PCI. In another study, the most common acute toxic events were fatigue (30% of patients in the standard-dose group vs 34% in the higher-dose group), headache (24% vs 28%), and nausea or vomiting (23% vs 28%).
- False-positive or false-negative results of imaging
- Treatment-related toxicity

Qualifying Statements

Qualifying Statements

- American College of Chest Physicians (ACCP) guidelines are intended for general information only, are not medical advice, and do not replace professional medical care and physician advice, which always should be sought for any medical condition. The complete disclaimer for this guideline can be accessed at the CHEST Web site.
- Although the ACCP is moving toward the production of evidence profiles for all guideline recommendations, there were many recommendations for which profiles were not developed, mostly because of resource constraints. When possible, methodologists created evidence profiles, and all panelists were educated on how to read and interpret them. The population, intervention, comparator, and outcome (PICO)-based systematic literature review process was followed for most recommendations, but there were some that could have benefited from meta-analyses.
- One limitation of all guidelines today is that they are not able to adequately address complex patients with multiple morbidities. This is largely because these patients are generally excluded from clinical trials and are often not included in observational studies. Since guidelines are reliant on evidence published in the peer-reviewed literature, the scientific foundation impedes the process of providing good guidance for these patients and is a limitation in these guidelines. Therefore, the ACCP encourages funding agencies to ensure that topics with limited evidence are addressed in future research.
Implementation of the Guideline

Description of Implementation Strategy

Dissemination and Implementation

These guidelines are widely disseminated through the CHEST journal publication, National Guideline Clearinghouse, and Guidelines International Network library. Additional clinical resources will soon be available to users of CHEST Evidence, an upcoming tool for searching the content of America College of Chest Physicians (ACCP) guidelines.

As the expanding research into diagnostic techniques and treatment options continues to evolve, the guidelines must be updated and kept current. This edition of the ACCP Lung Cancer Guidelines will be the last to be published as a complete collection, as the ACCP is now embarking on a new living guidelines model (LGM) for revising existing recommendations and developing new recommendations as the literature evolves. This will include a continual assessment of the currency of these recommendations relevant to new research studies as they are published. The review cycle for the ACCP Lung Cancer Guidelines will begin 1 year after publication unless the content experts who monitor the literature bring a recommendation or set of related recommendations to the attention of the Guideline oversight Committee (GOC), suggesting that those recommendations are in need of updating sooner. The new LGM will permit a more nimble approach to guideline development but also requires a point-of-care accessible vehicle, CHEST Evidence, for the users to readily search for the most current version. These features will be described in greater detail in upcoming publications. As a step in this direction, these guidelines will be published primarily online with a printed version of the Executive Summary, containing all of the recommendations, the introduction, and this article on methodology. All narratives for each article with their supporting tables, figures, and algorithms will be available online at journal.publications.chestnet.org.

Implementation Tools

Mobile Device Resources

Patient Resources

Quick Reference Guides/Physician Guides

Resources

For information about availability, see the Availability of Companion Documents and Patient Resources fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability
Bibliographic Source(s)


Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2003 Jan (revised 2013 May)

Guideline Developer(s)

American College of Chest Physicians - Medical Specialty Society

Source(s) of Funding

- The development of this guideline was supported primarily by the American College of Chest Physicians (ACCP). The lung cancer guidelines conference was supported in part by a grant from the Lung Cancer Research Foundation. The publication and dissemination of the guidelines was supported in part by a 2009 independent educational grant from Boehringer Ingelheim Pharmaceuticals, Inc.
- Role of sponsors: The ACCP was solely responsible for the development of these guidelines. The remaining supporters played no role in the development process. External supporting organizations cannot recommend panelists or topics, nor are they allowed prepublication access to the manuscripts and recommendations. Further details on the Conflict of Interest (COI) Policy are available online at [http://chestnet.org](http://chestnet.org).
- See the methodology companion (see the "Availability of Companion Documents" field) for a complete discussion of the source of funding for this guideline.

Guideline Committee

American College of Chest Physicians (ACCP) Expert Panel on Lung Cancer Guidelines

Composition of Group That Authored the Guideline

Authors: James R. Jett, MD, FCCP; Steven E. Schild, MD; Kenneth A. Kesler, MD, FCCP; Gregory P. Kalemkerian, MD

Financial Disclosures/Conflicts of Interest

- Conflicts of Interest (COI) grids reflecting the conflicts of interest that were current as of the date of the conference and voting are posted in the online supplementary materials.
- Financial/nonfinancial disclosures: The authors have reported to CHEST the following conflicts of interest: Dr Jett has received research funding paid to his institution for clinical trials related to early detection of lung cancer from Oncimmune LLC (biomarkers) and Metabolomic (breath analysis). Dr Kalemkerian receives research grant funding for clinical research from Eli Lilly and Company. Drs Schild and Kesler have reported that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.
- See the methodology companion (see the "Availability of Companion Documents" field) for a complete discussion of the conflict of interest
procedures and requirements for the guideline panel.

Guideline Endorser(s)

American Association for Bronchology and Interventional Pulmonology - Medical Specialty Society
European Society of Thoracic Surgeons - Professional Association
Oncology Nursing Society - Professional Association
Society of Thoracic Surgeons - Medical Specialty Society

Guideline Status

This is the current release of the guideline.


Guideline Availability

Available to subscribers of Chest - The Cardiopulmonary and Critical Care Journal. Also available to Chest subscribers through the Chest app for iPhone and iPad.

Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.

Availability of Companion Documents

The following are available:


Print copies: Available from the American College of Chest Physicians, Products and Registration Division, 3300 Dundee Road, Northbrook IL 60062-2348.
The following is also available:


A lung cancer staging calculator is available from the Staging Lung Cancer Web site.

Patient Resources

The following is available:


Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI on September 3, 2003. The information was verified by the guideline developer on October 1, 2003. This NGC summary was updated by ECRI Institute on November 28, 2007. The updated information was verified by the guideline developer on December 21, 2007. This NGC summary was updated by ECRI Institute on August 21, 2013.

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