NHS
National Institute for Health and Clinical Excellence

Quick reference guide

Issue date: April 2011

Lung cancer

The diagnosis and treatment of lung cancer

This updates and replaces NICE clinical guideline 24

NICE clinical guideline 121
Developed by the National Collaborating Centre for Cancer

About this booklet

This is a quick reference guide that summarises the recommendations NICE has made to the NHS in 'Lung cancer: the diagnosis and treatment of lung cancer' (NICE clinical guideline 121).

This guidance updates and replaces NICE clinical guideline 24 (published February 2005). New and updated recommendations are included on communication, diagnosis and staging, selection of patients with NSCLC for treatment with curative intent, surgery with curative intent for NSCLC, smoking cessation, combination treatment for NSCLC, treatment for SCLC, managing endobronchial obstruction, managing brain metastases, and follow-up and patient perspectives.

Since publication of NICE clinical guideline 24 in 2005, a number of new systemic therapies have been granted a marketing authorisation by the European Medicines Agency for use in people with NSCLC. NICE has published technology appraisals for pemetrexed, gefitinib and erlotinib. Other technology appraisals are in development.

The NHS has also commissioned a review of first-line therapy for NSCLC through the NIHR Health Technology Assessment Programme. This review is due to be published in 2011.

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NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Contents

Introduction

There are more than 39,000 new cases of lung cancer in the UK each year and more than 35,000 people die from the condition. Only about 5.5% of lung cancers are currently cured. Although the cure rate is rising slowly, the rate of improvement has been slower than for other common cancers. Outcomes in the UK are worse than those in some European countries and North America. There is also evidence that outcomes vary within the UK, which – among other factors – may be explained by variations in the standard of care.

This updated guideline provides recommendations for good practice in the diagnosis and treatment of non-small-cell (NSCLC) and small-cell lung cancer (SCLC).

Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Follow advice on seeking consent from the Department of Health or Welsh Assembly Government if needed. If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Key priorities for implementation

The importance of early diagnosis

- The public needs to be better informed of the symptoms and signs that are characteristic of lung cancer, through coordinated campaigning to raise awareness.

Communication

- Ensure that a lung cancer clinical nurse specialist is available at all stages of care to support patients and carers.

Diagnosis and staging

- Choose investigations that give the most information about diagnosis and staging with the least risk to the patient. Think carefully before performing a test that gives only diagnostic pathology when information on staging is also needed to guide treatment.
- Offer PET-CT, or EBUS-guided TBNA, or EUS-guided FNA, or non-ultrasound-guided TBNA as the first test for patients with an **intermediate probability of mediastinal malignancy** (lymph nodes between 10 and 20 mm maximum short axis on CT) who are potentially suitable for treatment with curative intent.

Surgery with curative intent for non-small-cell lung cancer

- Offer patients with NSCLC who are medically fit and suitable for treatment with curative intent, lobectomy (either open or thoracoscopic) as the treatment of first choice. For patients with borderline fitness and smaller tumours (T1a–b, N0, M0), consider lung parenchymal-sparing operations (segmentectomy or wedge resection) if a complete resection can be achieved.

Radiotherapy with curative intent for non-small-cell lung cancer

- Radical radiotherapy is indicated for patients with stage I, II or III NSCLC who have good performance status (WHO 0, 1) and whose disease can be encompassed in a radiotherapy treatment volume without undue risk of normal tissue damage[1].

Combination treatment for non-small-cell lung cancer

- Ensure all patients potentially suitable for multimodality treatment (surgery, radiotherapy and chemotherapy in any combination) are assessed by a thoracic oncologist and by a thoracic surgeon.

continued

[1] The GDG recognised that radiotherapy techniques have advanced considerably since the 2005 guideline and centres would reasonably wish to offer these techniques (including SBRT and 4-D planning) to patients. These treatments have the advantage of reducing the risk of damage to normal tissue (estimated by using measurements such as V20).

Assessing patients with small-cell lung cancer

- Arrange for patients with small-cell lung cancer (SCLC) to have an assessment by a thoracic oncologist within 1 week of deciding to recommend treatment.

Managing endobronchial obstruction

- Every cancer network should ensure that patients have rapid access to a team capable of providing interventional endobronchial treatments.

Follow-up and patient perspectives

- Offer all patients an initial specialist follow-up appointment within 6 weeks of completing treatment to discuss ongoing care. Offer regular appointments thereafter, rather than relying on patients requesting appointments when they experience symptoms.

Key priorities are shaded where they appear on pages 7–17.

Key to terms

EBUS – endobronchial ultrasound

EUS – endoscopic ultrasound

FNA – fine needle aspiration

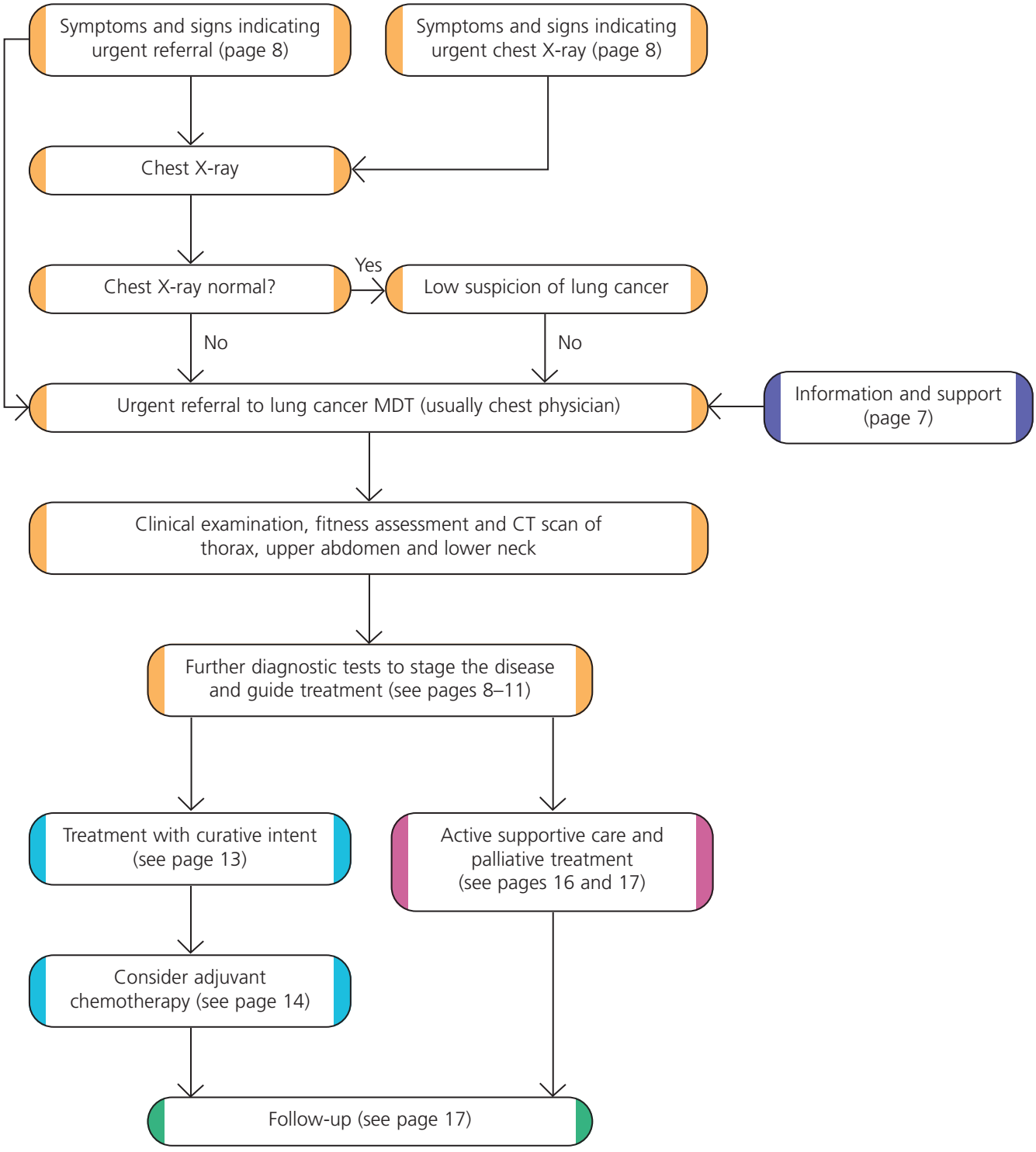
MDT – multidisciplinary team

NSCLC – non-small-cell lung cancer

SCLC – small-cell lung cancer

TBNA – transbronchial needle aspiration

Overview of care pathway



Information and support

- Raise awareness of the symptoms and signs of lung cancer through coordinated campaigning.
- Ensure that a lung cancer clinical nurse specialist is available at all stages of care to support patients and carers.

Effective communication with patients

- Find out what the patient knows about their condition without assuming a level of knowledge.
- Offer accurate and easy-to-understand information and ensure all communications are worded to assist understanding.
- Explain treatment options (including potential survival benefits, side effects and effect on symptoms) in a private environment, with the support of carers and the time to make an informed choice.
- Consider tailor-made decision aids to help patients understand probable outcomes, weigh up possible benefits and harms and make decisions about treatments.
- Offer patients a record of all discussions and a copy of correspondence with other healthcare professionals, but **avoid giving bad news by letter**.
- Only give bad news by phone in exceptional circumstances.
- When appropriate, sensitively offer to discuss end-of-life care. If possible, avoid leaving this until the terminal stages, but respect the patient's choice if they do not wish to confront future issues.
- Ensure patients know how to contact the lung cancer clinical nurse specialist between scheduled hospital visits.

Effective communication among the MDT

- Document discussions with the patient about end-of-life care, particularly about the patient's specific concerns, their understanding of the prognosis, and important values and preferences for care and treatment.
- Share information between healthcare professionals about the management plan, what the patient has been told and has understood, any problems, any advance decision and the involvement of other agencies.
- Send a copy of the radiologist's report to a designated member of the lung cancer MDT (usually the chest physician) when a chest X-ray incidentally suggests lung cancer. Ensure the MDT has a mechanism for following up these reports with the patient's GP.
- Discuss care of patients with a working diagnosis of lung cancer at a lung cancer MDT meeting.

Diagnosis and staging

Referral

Symptoms and signs indicating urgent chest X-ray

- Offer urgent chest X-ray to patients presenting with haemoptysis, or any of the following if unexplained or present for more than 3 weeks:
  - cough
  - chest/shoulder pain
  - dyspnoea
  - finger clubbing
  - signs suggesting metastases (for example, in brain, bone, liver or skin)
  - weight loss
  - chest signs
  - hoarseness
  - cervical/supraclavicular lymphadenopathy.

Symptoms and signs indicating urgent referral

- Offer urgent referral to lung cancer MDT (usually the chest physician) while waiting for chest X-ray results if any of the following are present:
  - persistent haemoptysis in a smoker or ex-smoker older than 40 years
  - signs of superior vena cava obstruction (swelling of the face and/or neck with fixed elevation of jugular venous pressure)
  - stridor.
- Offer urgent referral to lung cancer MDT (usually the chest physician) if:
  - a chest X-ray or CT scan suggests lung cancer (including pleural effusion and slowly resolving consolidation) **or**
  - chest X-ray is normal but there is a high suspicion of lung cancer.

Effectiveness of diagnostic and staging investigations

- Offer patients with known or suspected lung cancer a contrast-enhanced CT scan of the chest liver and adrenals[2].
- Biopsy enlarged mediastinal nodes (≥ 10 mm maximum short axis on CT) or other lesions in preference to primary lesion if determination of stage affects treatment.
- Every cancer network should have rapid access to PET-CT scanning.
- Ensure all patients potentially suitable for treatment with curative intent are offered PET-CT before treatment.
- Reserve sputum cytology for patients with centrally placed nodules or masses who are unable to tolerate bronchoscopy or other invasive tests.
- Do not use MRI routinely to stage the primary tumour in NSCLC.

[2] This recommendation was outside the scope of the 2011 update but the GDG recognised that many centres include the lower neck when performing CT scans for the diagnosis of lung cancer. The GDG also recognised that contrast medium should only be given with caution to patients with known renal impairment.

- Where necessary use MRI to assess the extent of disease for patients with superior sulcus tumours.
- Every cancer network should have at least one centre with EBUS and/or EUS.
- Offer EBUS-guided TBNA for biopsy of paratracheal and peri-bronchial intra-parenchymal lung lesions.
- Audit the local test performance of non-ultrasound-guided TBNA, EBUS and EUS-guided FNA.
- Take adequate samples without unacceptable risk to the patient to permit detailed pathological diagnosis including tumour sub-typing and measurement of predictive markers.

Stage M1b

- Confirm isolated distant metastases/synchronous tumours by biopsy or further imaging (for example, MRI or PET-CT) in patients being considered for treatment with curative intent.

Intracranial pathology

- Consider MRI or CT of the head in patients selected for treatment with curative intent, especially in stage III disease.
- Offer patients with features suggestive of intracranial pathology, CT of the head followed by MRI if normal, or MRI as an initial test.

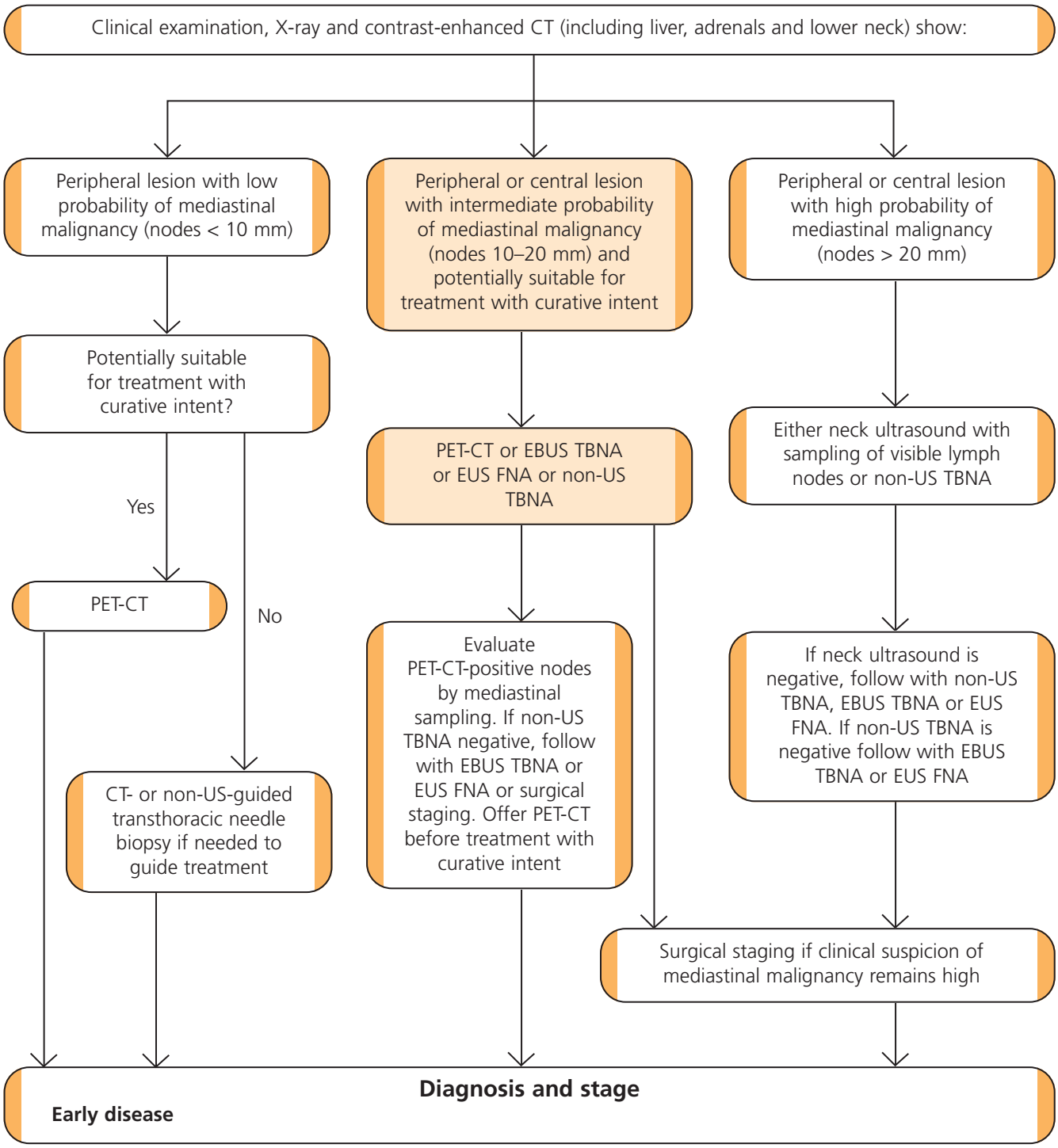
Bone metastasis

- Perform an X-ray for localised signs and symptoms of bone metastasis. If negative or inconclusive, offer bone scintigraphy or MRI.
- Avoid bone scintigraphy when PET-CT has not shown bone metastases.

Organisational factors relevant to diagnosis and staging

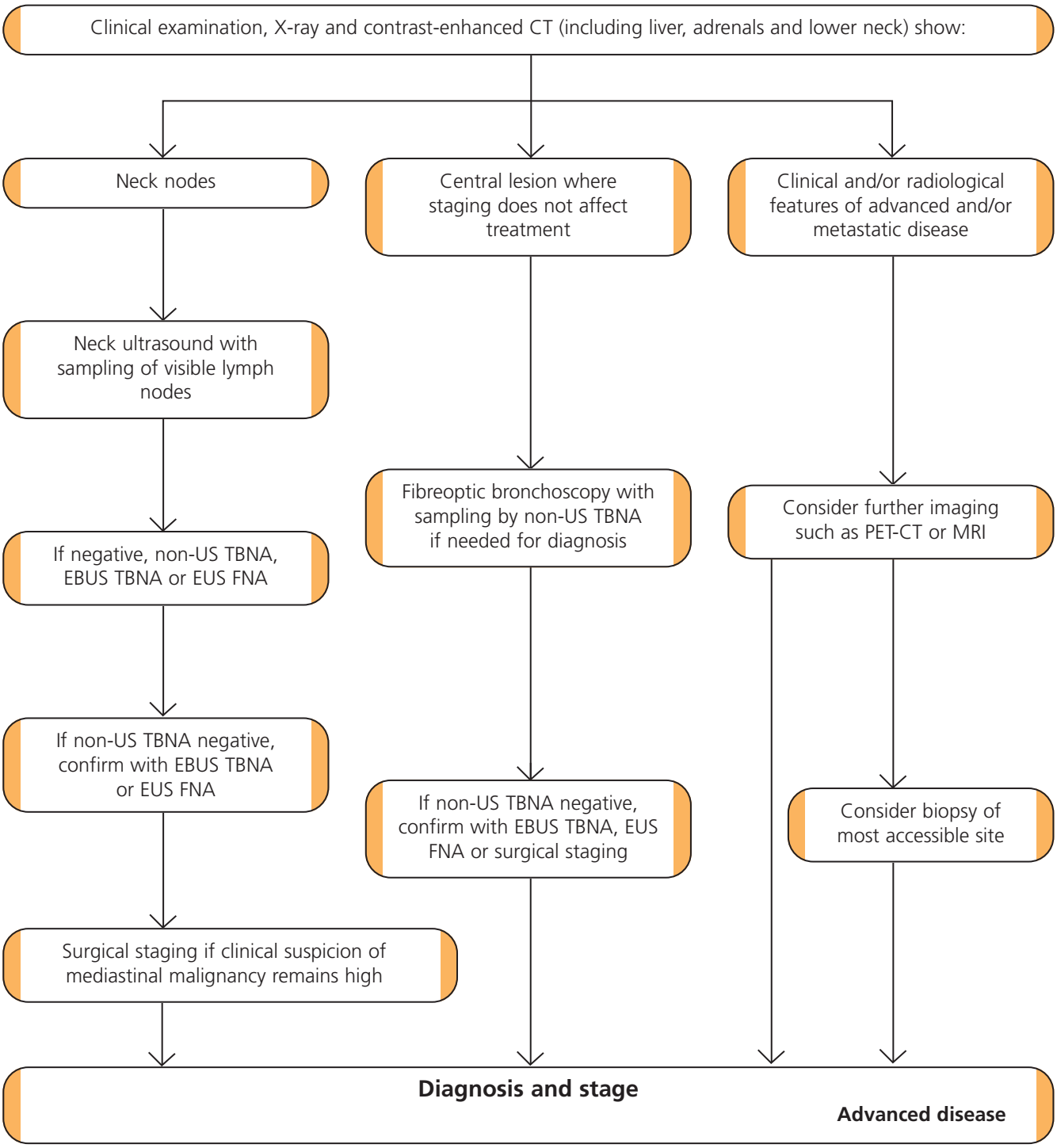
- Provide rapid access clinics where possible for the investigation of suspected lung cancer, because they are associated with faster diagnosis and less patient anxiety.
- All cancer units/centres should have one or more trained lung cancer clinical nurse specialists to see patients before and after diagnosis, to provide continuing support and to facilitate communication between the secondary care team (including the MDT), the patient's GP, the community team and the patient. Their role includes helping patients to access advice and support whenever they need it.

Sequence of investigations



- Choose investigations that give the most information with the least risk. Think carefully about performing tests that give only diagnostic pathology when information on staging is needed to guide treatment.

Sequence of investigations *continued*



- Choose investigations that give the most information with the least risk. Think carefully about performing tests that give only diagnostic pathology when information on staging is needed to guide treatment.

Treatment

Assessing fitness for treatment with curative intent

	Assessments	Actions following assessments
Perioperative mortality	Consider global risk score such as Thoracoscore	Ensure patient is aware of risk before consenting to surgery
Cardiovascular function	Assess risk factors and cardiac functional capacity	Avoid surgery within 30 days of MI Optimise primary cardiac treatment and begin secondary cardiac prophylaxis as soon as possible Offer surgery if two or fewer risk factors and good cardiac functional capacity Seek cardiology review if active cardiac condition, three or more risk factors or poor cardiac functional capacity Consider revascularisation before surgery in stable angina Continue anti-ischaemic treatment in perioperative period. Discuss perioperative platelet treatment if patient has a coronary stent
Lung function	Perform spirometry, measure T_LCO if disproportionate breathlessness or other lung pathology, perform segment count and assess exercise tolerance **And** Consider shuttle walk testing (cut-off 400 m) and cardiopulmonary exercise testing (cut-off 15 ml/kg/minute) if moderate to high risk of postoperative dyspnoea	Offer surgery if normal FEV_1 and good exercise tolerance or FEV_1 or T_LCO below 30% and patient accepts the risks of dyspnoea Offer radiotherapy with curative intent if lung function poor but patient is otherwise suitable for radiotherapy with curative intent and volume of irradiated lung is small

- Offer treatment within 31 days of the decision to treat and within 62 days of urgent referral.

Smoking cessation

- Do not postpone surgery to allow patients to stop smoking.
- Advise patients to stop smoking as soon as lung cancer is suspected and tell them that smoking increases the risk of complications after surgery.
- Offer nicotine replacement therapy and other therapies in line with 'Smoking cessation services' (NICE public health guidance 10) and 'Varenicline for smoking cessation' (NICE technology appraisal guidance 123).

Surgery with curative intent for non-small-cell lung cancer

- Offer patients with NSCLC who are fit for surgery, open or thoracoscopic lobectomy as the treatment of first choice. If complete resection is possible, consider segmentectomy or wedge resection for patients with smaller tumours (T1a-b, N0, M0) and borderline fitness.
- Offer more extensive surgery (bronchoangioplastic surgery, bilobectomy, pneumonectomy) only when needed to obtain clear margins.
- Perform hilar and mediastinal lymph node sampling or en bloc resection for all patients undergoing surgery with curative intent.
- For T3 NSCLC with chest wall involvement, aim for complete resection by extrapleural or en bloc chest wall resection.

Radiotherapy with curative intent for non-small-cell lung cancer

- A clinical oncologist specialising in thoracic oncology should determine suitability for radiotherapy with curative intent, taking into account performance status and comorbidities.
- Assess lung function before offering radiotherapy with curative intent.
- Offer radiotherapy with curative intent to patients with stage I, II or III NSCLC and good performance status if there is no undue risk of normal tissue damage[3].
- Offer CHART for radiotherapy with curative intent to:
  - patients with stage I or II NSCLC who are medically inoperable but are suitable for radiotherapy with curative intent
  - patients with stage IIIA or IIIB NSCLC who are suitable for radiotherapy with curative intent and who cannot tolerate or do not want chemoradiotherapy.
- If CHART is not available, offer conventionally fractionated radiotherapy to a dose of 64–66 Gy in 32–33 fractions over 61/2 weeks or 55 Gy in 20 fractions over 4 weeks.
- Patients receiving radiotherapy with curative intent should be part of a national quality assurance programme.

[3] The GDG recognised that radiotherapy techniques have advanced considerably since the 2005 guideline and centres would reasonably wish to offer these techniques (including SBRT and 4-D planning) to patients. These treatments have the advantage of reducing the risk of damage to normal tissue (estimated by using measurements such as V20).

Combination treatment for non-small-cell lung cancer

- Ensure all patients potentially suitable for multimodality treatment (surgery, radiotherapy and chemotherapy in any combination) are assessed by a thoracic oncologist and by a thoracic surgeon.

- Consider chemoradiotherapy for patients with stage II or III NSCLC who are not suitable for surgery. Balance the potential benefit in survival with the risk of additional toxicities.
- Ensure eligible patients have the benefit of detailed discussion of the risks and benefits of adjuvant chemotherapy.
- Offer postoperative chemotherapy to patients with good performance status (WHO 0 or 1) and T1–3 N1–2 M0 NSCLC.
- Consider postoperative chemotherapy in patients with good performance status (WHO 0 or 1) and T2–3 N0 M0 NSCLC with tumours greater than 4 cm in diameter.
- Offer a cisplatin-based combination chemotherapy regimen for adjuvant chemotherapy.
- For patients with NSCLC who are suitable for surgery, do not offer neo-adjuvant chemotherapy outside a clinical trial.
- Treat Pancoast tumours in the same way as other types of NSCLC. Offer multimodality therapy according to resectability, stage and performance status.

Chemotherapy for non-small-cell lung cancer

- Offer chemotherapy to patients with stage III or IV NSCLC and good performance status (WHO 0, 1 or a Karnofsky score of 80–100).
- For advanced NSCLC, offer a combination of a single third-generation drug (docetaxel, gemcitabine, paclitaxel or vinorelbine) plus a platinum drug (either carboplatin or cisplatin).
- If patients cannot tolerate a platinum combination, offer single-agent chemotherapy with a third-generation drug.
- Consider docetaxel monotherapy for second-line treatment of locally advanced or metastatic NSCLC when cancer has relapsed after previous chemotherapy.
- For technology appraisal guidance on the use of gefitinib, pemetrexed and erlotinib for the treatment of NSCLC, refer to the NICE website at **www.nice.org.uk**

Treatment for small-cell lung cancer

- Arrange for patients with SCLC to have an assessment by a thoracic oncologist within 1 week of deciding to recommend treatment.

	Early-stage (broadly T1–2a, N0, M0)	Limited disease (broadly T1–4, N0-3, M0)	Extensive disease (broadly T1–4, N0–3, M1a/b)
First-line treatment	Consider surgery		
	Offer 4–6 cycles of cisplatin based combination chemotherapy. Consider carboplatin if renal function impaired, poor performance status (WHO 2 or more) or significant comorbidity Offer concurrent chemoradiotherapy if good performance status (WHO 0 or 1) and disease encompassed in radical radiotherapy volume. Start radiotherapy during first or second chemotherapy cycle Offer sequential radical radiotherapy within 6 weeks of completion of chemotherapy if patient is unfit for concurrent chemoradiotherapy and has responded to chemotherapy		Offer platinum-based combination chemotherapy (maximum 6 cycles) if patient can receive chemotherapy Assess response and toxicity before each cycle Consider thoracic radiotherapy after chemotherapy if complete response at distant sites and at least a good partial response in the thorax
Prophylactic cranial irradiation	Offer at a dose of 25 Gy in 10 fractions to patients with complete or partial response after first-line treatment and good performance status (WHO 2 or less)		
Second-line treatment	Offer assessment by a thoracic oncologist when SCLC relapses after first-line treatment If suitable, offer treatment with an anthracycline-containing regimen or further platinum chemotherapy (maximum 6 cycles) Inform patients that there is limited evidence that second-line chemotherapy will be beneficial if there has been no response to first-line treatment Offer radiotherapy for palliation of local symptoms Refer to 'Topotecan for the treatment of small-cell lung cancer' (NICE technology appraisal guidance 184), available at **www.nice.org.uk/guidance/TA184**		
Maintenance treatment	Do not offer outside a clinical trial		

Palliative care

Providing palliative care

- Supportive and palliative care should be provided by general and specialist palliative care providers in line with 'Improving supportive and palliative care for adults with cancer' (NICE cancer service guidance).
- Identify patients who may benefit from specialist palliative care services and refer them without delay.

Palliative radiotherapy

- Offer palliative radiotherapy immediately to patients who cannot be offered curative treatment, or wait until symptoms arise.

Managing endobronchial obstruction

- Every cancer network should have rapid access to interventional endobronchial treatments.

- When patients have large airway involvement, monitor (clinically and radiologically) for endobronchial obstruction to ensure treatment is offered early.
- Offer external beam radiotherapy and/or endobronchial debulking or stenting to patients with impending endobronchial obstruction.

Managing brain metastases

- Offer dexamethasone to patients with symptomatic brain metastases and reduce to the minimum necessary maintenance dose for symptomatic response.
- Consider palliative whole-brain radiotherapy for patients with symptomatic brain metastases and good performance status (WHO 0 or 1).

Managing bone metastases

- Offer single-fraction radiotherapy for palliation of bone pain when standard analgesic treatments are inadequate.

Managing pleural effusion

- Offer pleural aspiration or drainage to relieve symptoms of pleural effusion.
- Offer patients who benefit from aspiration or drainage of fluid, pleurodesis for longer-term benefit.

Managing breathlessness, cough and hoarseness

- Consider psychosocial support, breathing control and coping strategies for breathlessness. This should be delivered by a multidisciplinary group, coordinated by a professional with an interest and expertise in breathlessness. Patients should have access to this in all care settings.
- Consider opioids, such as codeine or morphine, to reduce cough.
- Refer patients with troublesome hoarseness due to recurrent laryngeal nerve palsy to an ear, nose and throat specialist.

Managing superior vena cava obstruction

- Offer chemotherapy and radiotherapy according to the stage of disease and performance status.
- Consider stent insertion for the immediate relief of severe symptoms or following failure of earlier treatment.

Managing other symptoms

- Offer supportive and palliative care for other symptoms, including weight loss, loss of appetite, depression and difficulty swallowing.

Follow-up

- Offer an initial specialist follow-up appointment within 6 weeks of completing treatment to discuss ongoing care. Offer regular appointments thereafter, rather than relying on patients requesting appointments when they experience symptoms.

- Offer protocol-driven follow-up led by a lung cancer clinical nurse specialist as an option for patients with a life expectancy of more than 3 months.
- Collect the opinion and experiences of lung cancer patients and carers to improve the delivery of services. Ensure patients receive feedback on any action taken as a result of such surveys.

Further information

Ordering information

You can download the following documents from **www.nice.org.uk/guidance/CG121**

- The NICE guideline – all the recommendations.
- A quick reference guide (this document) – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for patients and carers.
- The full guideline – all the recommendations, details of how they were developed, and reviews of the evidence they were based on.

For printed copies of the quick reference guide or 'Understanding NICE guidance', phone NICE publications on 0845 003 7783 or email publications@nice.org.uk and quote:

- N2502 (quick reference guide)
- N2503 ('Understanding NICE guidance').

Implementation tools

NICE has developed tools to help organisations implement this guidance (see **www.nice.org.uk/guidance/CG121**).

Related NICE guidance

For information about NICE guidance that has been issued or is in development, see **www.nice.org.uk**

Published

- Gefitinib for the first-line treatment of locally advanced or metastatic non-small-cell lung cancer. NICE technology appraisal guidance 192 (2010). Available from **www.nice.org.uk/guidance/TA192**
- Pemetrexed for the maintenance treatment of non-small-cell lung cancer. NICE technology appraisal guidance 190 (2010). Available from **www.nice.org.uk/guidance/TA190**
- Percutaneous radiofrequency ablation for primary and secondary lung cancers. NICE interventional procedure guidance 372 (2010). Available from **www.nice.org.uk/guidance/IPG372**
- Topotecan for the treatment of relapsed small-cell-lung cancer. NICE technology appraisal guidance 184 (2009). Available from **www.nice.org.uk/guidance/TA184**
- Pemetrexed for the first-line treatment of non-small cell-lung cancer. NICE technology appraisal guidance 181 (2009). Available from **www.nice.org.uk/guidance/TA181**
- Erlotinib for the treatment of non-small cell lung cancer. NICE technology appraisal guidance 162 (2008). Available from **www.nice.org.uk/guidance/TA162**
- Bevacizumab for the treatment of non-small-cell lung cancer (terminated appraisal). NICE technology appraisal 148 (2008). See **www.nice.org.uk/guidance/TA148**
- Endobronchial ultrasound-guided transbronchial needle aspiration for mediastinal masses. NICE interventional procedure guidance 254 (2008). Available from **www.nice.org.uk/guidance/IPG254**
- Smoking cessation services. NICE public health guidance 10 (2008). Available from **www.nice.org.uk/guidance/PH10**
- Pemetrexed for the treatment of non-small-cell lung cancer. NICE technology appraisal guidance 124 (2007). Available from **www.nice.org.uk/guidance/TA124**

- Varenicline for smoking cessation. NICE technology appraisal guidance 123 (2007). Available from **www.nice.org.uk/guidance/TA123**
- Workplace interventions to promote smoking cessation. NICE public health guidance 5 (2007). Available from **www.nice.org.uk/guidance/PH5**
- Brief interventions and referral for smoking cessation. NICE public health guidance 1 (2006). Available from **www.nice.org.uk/guidance/PH1**
- Referral guidelines for suspected cancer. NICE clinical guideline 27 (2005). Available from **www.nice.org.uk/guidance/CG27**
- Cryotherapy for malignant endobronchial obstruction. NICE interventional procedure guidance 142 (2005). Available from **www.nice.org.uk/guidance/IPG142**
- Photodynamic therapy for localised inoperable endobronchial cancer. NICE interventional procedure guidance 137 (2005). Available from **www.nice.org.uk/guidance/IPG137**
- Photodynamic therapy for advanced bronchial carcinoma. NICE interventional procedure guidance 87 (2004). Available from **www.nice.org.uk/guidance/IPG87**
- Improving supportive and palliative care for adults with cancer. NICE cancer service guidance (2004). Available from **www.nice.org.uk/guidance/csgsp**

Under development

- Erlotinib monotherapy for the maintenance treatment of non-small-cell lung cancer. NICE technology appraisal guidance. Publication date to be confirmed.
- Smoking cessation in secondary care. NICE public health guidance. Publication date to be confirmed.

Updating the guideline

This guideline will be updated as needed, and information about the progress of any update will be available at **www.nice.org.uk/guidance/CG121**

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