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Lung Cancer Early Detection, Diagnosis, and Staging

Detection and Diagnosis

Catching cancer early often allows for a higher likelihood of successful treatment. Some early cancers may have signs and symptoms that can be noticed, but that is not always the case.

- [Can Lung Cancer Be Found Early?](#)
- [Signs and Symptoms of Lung Cancer](#)
- [Tests for Lung Cancer](#)
- [Understanding Your Pathology Report¹](#)

Stages and Outlook (Prognosis)

After a cancer diagnosis, staging provides important information about the extent of cancer in the body and anticipated response to treatment.

- [Non-Small Cell Lung Cancer Stages](#)
- [Small Cell Lung Cancer Stages](#)
- [Lung Cancer Survival Rates](#)

Questions to Ask About Lung Cancer

Here are some questions you can ask your cancer care team to help you better understand your cancer diagnosis and treatment options.

- [Questions to Ask About Lung Cancer](#)

Can Lung Cancer Be Found Early?

Screening is the use of tests or exams to find a disease in people who don't have symptoms. Regular chest x-rays have been studied for lung cancer screening, but they did not help most people live longer. In recent years, a test known as a low-dose CAT scan or CT scan (LDCT) has been studied in people at a higher risk of getting lung cancer. LDCT scans can help find abnormal areas in the lungs that may be cancer. Research has shown that using LDCT scans to screen people at higher risk of lung cancer saved more lives compared to chest x-rays. For higher risk people, getting yearly LDCT scans before symptoms start helps lower the risk of dying from lung cancer.

Reasons to screen for lung cancer

In the United States, lung cancer is the second most common cancer in both men and women. It's also the leading cause of death from cancer.

If lung cancer is found at an earlier stage, when it is small and before it has spread, it is more likely to be successfully treated.

Usually [symptoms of lung cancer](#)¹ do not appear until the disease is already at an advanced [stage](#)². Even when lung cancer does cause symptoms, many people may mistake them for other problems, such as an infection or long-term effects from smoking. This may delay the diagnosis.

Current and former smokers are at a higher risk of getting lung cancer.

American Cancer Society's guidelines for lung cancer screening

The American Cancer Society (ACS) has a lung cancer screening guideline for people with a higher risk of getting lung cancer that is based on the National Lung Screening Trial (which is described below). The ACS recommends yearly lung cancer screening with LDCT scans for people who are 55 to 74 years old, are in fairly good health, and who also meet the following conditions:

- Are current smokers or smokers who have quit in the past 15 years. **and**
- Have at least a 30 pack-year smoking history. (This is the number of years you smoked multiplied by the number of packs of cigarettes per day. For example, someone who smoked 2 packs per day for 15 years [2 x 15 = 30] has 30 pack-years of smoking. A person who smoked 1 pack per day for 30 years [1 x 30 = 30] also has 30 pack-years of smoking.) **and**
- Receive counseling to quit smoking if they are current smokers. **and**
- Have been told by their doctor about the possible benefits, limits, and harms of screening with LDCT scans. **and**
- Have a facility where they can go that has experience in lung cancer screening and treatment.

Benefits of lung cancer screening

The main benefit of screening is a lower chance of dying from lung cancer, which accounts for many deaths in current and former smokers. Still, it's important to be aware that, as with any type of screening, not everyone who gets screened will benefit. Screening with LDCT will not find all lung cancers, and not all of the cancers that are found will be found early.

Even if a cancer is found by screening, you may still die from lung cancer. Also, LDCT often finds things that turn out not to be cancer, but have to be checked out with more tests to know what they are. You might need more CT scans, or invasive tests such as a lung biopsy, in which a piece of lung tissue is removed with a needle or during surgery. These tests have risks of their own (see above).

If you are at a higher risk, your doctor can explain your risk and how the ACS lung cancer screening guideline applies to you. Your doctor can also talk with you about what happens during screening and the best places to get the yearly screening test. Lung cancer screening is covered by Medicare and by many private health insurance plans. Your health care team can help you find out if your insurance will provide coverage.

Screening should only be done at facilities that have the right type of CT scanner and that have experience in LDCT scans for lung cancer screening. The facility should also have a team of specialists that can give patients the appropriate care and follow-up if there are abnormal results on the scans. You might not have the right kind of facility nearby, so you may need to travel some distance to be screened.

If you are at higher risk and should be screened, you should get a LDCT every year until you reach the age of 74, as long as you are still in good health.

If you smoke, you should get counseling about stopping. You should be told about your risk of lung cancer and referred to a smoking cessation program. **Screening is not a good alternative to stopping smoking. By quitting, smokers can lower their risk of getting and dying from lung cancer.** For help quitting, see [How To Quit Smoking and Smokeless Tobacco](#)³ or call the American Cancer Society at 1-800-227-2345.

What does “in fairly good health” mean?

Screening is meant to find cancer in people who do not have symptoms of the disease. People who already have symptoms that might be caused by lung cancer may need tests such as CT scans to find the underlying cause, which in some cases may be cancer. But this kind of testing is for diagnosis and is not the same as screening. Some of the possible symptoms of lung cancer that kept people out of the NLST were coughing up blood and weight loss without trying.

To get the most benefit from screening, patients need to be in good health. For example, they need to be able to have surgery and other treatments to try to cure lung cancer if it is found. Patients who need home oxygen therapy probably couldn't withstand having part of a lung removed, and so are not candidates for screening. Patients with other serious medical problems that would shorten their lives or keep them from having surgery might not benefit enough from screening for it to be worth the risks, and so should also not be screened.

Metal implants in the chest (like pacemakers) or back (like rods in the spine) can interfere with x-rays and lead to poor quality CT images of the lungs. People with these types of implants were also kept out of the NLST, and so should not be screened with CT scans for lung cancer according to the ACS guidelines.

If something abnormal is found during screening

Sometimes screening tests will show something abnormal in the lungs or nearby areas that might be cancer. Most of these abnormal findings will turn out not to be cancer, but more CT scans or other tests will be needed to be sure. Some of these tests are described in [Tests for Lung Cancer](#)⁴.

CT scans of the lungs can also sometimes show problems in other organs that just happen to be in the field of view of the scans. Your doctor will discuss any such findings with you if they are found.

The National Lung Screening Trial

The National Lung Screening Trial (NLST) was a large clinical trial that looked at using LDCT of the chest to screen for lung cancer. CT scans of the chest provide more detailed pictures than chest x-rays and are better at finding small abnormal areas in the lungs. Low-dose CT of the chest uses lower amounts of radiation than a standard chest CT and does not require the use of intravenous (IV) contrast dye.

The NLST compared LDCT of the chest to chest x-rays in people at high risk of lung cancer to see if these scans could help lower the risk of dying from lung cancer. The study included more than 50,000 people ages 55 to 74 who were current or former smokers and were in fairly good health. To be in the study, they had to have at least a 30 pack-year history of smoking.

Former smokers could enter the study if they had quit within the past 15 years. The study did not include people if they had a history of lung cancer or lung cancer symptoms, if they had part of a lung removed, if they needed to be on oxygen at home to help them breathe, or if they had other serious medical problems.

People in the study got either 3 LDCT scans or 3 chest x-rays, each a year apart, to look for abnormal areas in the lungs that might be cancer. After several years, the study found that people who got LDCT had a 20% lower chance of dying from lung cancer than those who got chest x-rays. They were also 7% less likely to die overall (from any cause) than those who got chest x-rays.

Screening with LDCT was also shown to have some downsides that need to be considered.

One drawback of this test is that it also finds a lot of abnormalities that have to be checked out with more tests, but that turn out not to be cancer. (About 1 out of 4 people in the NLST had such a finding.) This may lead to additional tests such as other CT scans or more invasive tests such as needle biopsies or even surgery to remove a portion of lung in some people. These tests can sometimes lead to complications (like a collapsed lung) or rarely, death, even in people who do not have cancer (or who have very early stage cancer).

LDCTs also exposes people to a small amount of radiation with each test. It is less than the dose from a standard CT, but it is more than the dose from a chest x-ray. Some people who are screened may end up needing further CT scans, which means more radiation exposure. When done in tens of thousands of people, this radiation may cause a few people to develop breast, lung, or thyroid cancers later on.

Hyperlinks

1. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/signs-symptoms.html
2. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/staging-nslc.html
3. www.cancer.org/healthy/stay-away-from-tobacco/guide-quitting-smoking.html
4. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/how-diagnosed.html

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Last Medical Review: October 1, 2019 Last Revised: October 1, 2019

Signs and Symptoms of Lung Cancer

Most lung cancers do not cause any symptoms until they have spread, but some people with early lung cancer do have symptoms. If you go to your doctor when you first notice symptoms, your cancer might be diagnosed at an earlier stage, when treatment is more likely to be effective.

Most of these symptoms are more likely to be caused by something other than lung cancer. Still, if you have any of these problems, it's important to see your doctor right away so the cause can be found and treated, if needed.

The most common symptoms of lung cancer are:

- A cough that does not go away or gets worse
- Coughing up blood or rust-colored sputum (spit or phlegm)
- Chest pain that is often worse with deep breathing, coughing, or laughing
- Hoarseness
- Loss of appetite
- Unexplained weight loss
- Shortness of breath
- Feeling tired or weak
- Infections such as bronchitis and pneumonia that don't go away or keep coming back
- New onset of wheezing

If lung cancer spreads to other parts of the body, it may cause:

- Bone pain (like pain in the back or hips)
- Nervous system changes (such as headache, weakness or numbness of an arm or leg, dizziness, balance problems, or seizures), from cancer spread to the brain
- Yellowing of the skin and eyes (jaundice), from cancer spread to the liver
- Swelling of lymph nodes (collection of immune system cells) such as those in the neck or above the collarbone

Some lung cancers can cause **syndromes**, which are groups of specific symptoms.

Horner syndrome

Cancers of the upper part of the lungs are sometimes called **Pancoast tumors**. These tumors are more likely to be non-small cell lung cancer (NSCLC) than small cell lung cancer (SCLC).

Pancoast tumors can affect certain nerves to the eye and part of the face, causing a group of symptoms called Horner syndrome:

- Drooping or weakness of one upper eyelid
- A smaller pupil (dark part in the center of the eye) in the same eye
- Little or no sweating on the same side of the face

Pancoast tumors can also sometimes cause severe shoulder pain.

Superior vena cava syndrome

The superior vena cava (SVC) is a large vein that carries blood from the head and arms down to the heart. It passes next to the upper part of the right lung and the lymph nodes inside the chest. Tumors in this area can press on the SVC, which can cause the blood to back up in the veins. This can lead to swelling in the face, neck, arms, and upper chest (sometimes with a bluish-red skin color). It can also cause headaches, dizziness, and a change in consciousness if it affects the brain. While SVC syndrome can develop gradually over time, in some cases it can become life-threatening, and needs to be treated right away.

Paraneoplastic syndromes

Some lung cancers make hormone-like substances that enter the bloodstream and cause problems with distant tissues and organs, even though the cancer has not spread to those places. These problems are called paraneoplastic syndromes. Sometimes these syndromes may be the first symptoms of lung cancer. Because the symptoms affect other organs, a disease other than lung cancer may first be suspected as causing them.

Paraneoplastic syndromes can happen with any lung cancer but are more often associated with SCLC. Some common syndromes include:

- **SIADH (syndrome of inappropriate anti-diuretic hormone):** In this condition, the cancer cells make ADH, a hormone that causes the kidneys to hold water. This lowers salt levels in the blood. Symptoms of SIADH can include fatigue, loss of appetite, muscle weakness or cramps, nausea, vomiting, restlessness, and

confusion. Without treatment, severe cases may lead to seizures and coma.

- **Cushing syndrome:** In this condition, the cancer cells make ACTH, a hormone that causes the adrenal glands to make cortisol. This can lead to symptoms such as weight gain, easy bruising, weakness, drowsiness, and fluid retention. Cushing syndrome can also cause high blood pressure, high blood sugar levels, or even diabetes.
- **Nervous system problems:** SCLC can sometimes cause the body's immune system to attack parts of the nervous system, which can lead to problems. One example is a muscle disorder called **Lambert-Eaton syndrome**. In this syndrome, muscles around the hips become weak. One of the first signs may be trouble getting up from a sitting position. Later, muscles around the shoulder may become weak. A less common problem is **paraneoplastic cerebellar degeneration**, which can cause loss of balance and unsteadiness in arm and leg movement, as well as trouble speaking or swallowing. SCLC can also cause other nervous system problems, such as muscle weakness, sensation changes, vision problems, or even changes in behavior.
- High levels of calcium in the blood (hypercalcemia), which can cause frequent urination, thirst, constipation, nausea, vomiting, belly pain, weakness, fatigue, dizziness, and confusion
- Blood clots

Again, many of these symptoms are more likely to be caused by something other than lung cancer. Still, if you have any of these problems, it's important to see your doctor right away so the cause can be found and treated, if needed.

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Last Medical Review: October 1, 2019 Last Revised: October 1, 2019

Tests for Lung Cancer

Some lung cancers can be found by screening, but most lung cancers are found because they are causing problems. The actual diagnosis of lung cancer is made by looking at a sample of lung cells in the lab. If you have possible [signs or symptoms of lung cancer](#)¹, see your doctor.

Medical history and physical exam

Your doctor will ask about your medical history to learn about your symptoms and possible [risk factors](#)². Your doctor will also examine you to look for signs of lung cancer or other health problems.

If the results of your history and physical exam suggest you might have lung cancer, more tests will be done. These could include imaging tests and/or biopsies of the lung.

Imaging tests to look for lung cancer

Imaging tests use x-rays, magnetic fields, sound waves, or radioactive substances to create pictures of the inside of your body. Imaging tests might be done for a number of reasons both before and after a diagnosis of lung cancer, including:

- To look at suspicious areas that might be cancer
- To learn how far cancer might have spread
- To help determine if treatment is working

- To look for possible signs of cancer coming back after treatment

Chest x-ray

A [chest x-ray](#)³ is often the first test your doctor will do to look for any abnormal areas in the lungs. If something suspicious is seen, your doctor may order more tests.

Computed tomography (CT) scan

A [CT scan](#)⁴ uses x-rays to make detailed cross-sectional images of your body. Instead of taking 1 or 2 pictures, like a regular x-ray, a CT scanner takes many pictures and a computer then combines them to show a slice of the part of your body being studied.

A CT scan is more likely to show lung tumors than routine chest x-rays. It can also show the size, shape, and position of any lung tumors and can help find enlarged lymph nodes that might contain cancer that has spread. This test can also be used to look for masses in the adrenal glands, liver, brain, and other organs that might be due to the lung cancer spread.

CT-guided needle biopsy: If a suspected area of cancer is deep within your body, a CT scan might be used to guide a biopsy needle into this area to get a tissue sample to check for cancer.

Magnetic resonance imaging (MRI) scan

Like CT scans, [MRI scans](#)⁵ show detailed images of soft tissues in the body. But MRI scans use radio waves and strong magnets instead of x-rays. MRI scans are most often used to look for possible spread of lung cancer to the brain or spinal cord.

Positron emission tomography (PET) scan

For a [PET scan](#)⁶, a slightly radioactive form of sugar (known as FDG) is injected into the blood and collects mainly in cancer cells.

PET/CT scan: Often a PET scan is combined with a CT scan using a special machine that can do both at the same time. This lets the doctor compare areas of higher radioactivity on the PET scan with a more detailed picture on the CT scan. This is the type of PET scan most often used in patients with lung cancer.

PET/CT scans can be useful:

- If your doctor thinks the cancer might have spread but doesn't know where. They can show spread of cancer to the liver, bones, adrenal glands, or some other organs. They are not as useful for looking at the brain or spinal cord.
- In diagnosing lung cancer, but their role in checking whether treatment is working is unproven. Most doctors do not recommend PET/CT scans for routine follow up of patients after lung cancer treatment.

Bone scan

For a [bone scan](#)⁷, a small amount of low-level radioactive material is injected into the blood and collects mainly in abnormal areas of bone. A bone scan can help show if a cancer has spread to the bones. But this test isn't needed very often because PET scans can usually show if cancer has spread to the bones.

Tests to diagnose lung cancer

Symptoms and the results of certain tests may strongly suggest that a person has lung cancer, but the actual diagnosis is made by looking at lung cells in the lab.

The cells can be taken from lung secretions (mucus you cough up from the lungs), fluid removed from the area around the lung (thoracentesis), or from a suspicious area using a needle or surgery ([biopsy](#)⁸). The choice of which test(s) to use depends on the situation.

Sputum cytology

A sample of sputum (mucus you cough up from the lungs) is looked at in the lab to see if it has cancer cells. The best way to do this is to get early morning samples 3 days in a row. This test is more likely to help find cancers that start in the major airways of the lung, such as squamous cell lung cancers. It might not be as helpful for finding other types of lung cancer. If your doctor suspects lung cancer, further testing will be done even if no cancer cells are found in the sputum.

Thoracentesis

If fluid has collected around the lungs (called a **pleural effusion**), doctors can remove some of the fluid to find out if it is caused by cancer spreading to the lining of the lungs (pleura). The buildup might also be caused by other conditions, such as heart failure or an infection.

For a thoracentesis, the skin is numbed and a hollow needle is inserted between the ribs to drain the fluid. The fluid is checked in the lab for cancer cells. Other tests of the fluid are also sometimes useful in telling a malignant (cancerous) pleural effusion from one that is not.

If a malignant pleural effusion has been diagnosed and is causing trouble breathing, a thoracentesis may be repeated to remove more fluid which may help a person breathe better.

Needle biopsy

Doctors often use a hollow needle to get a small sample from a suspicious area (mass). An advantage of needle biopsies is that they don't require a surgical incision. The drawback is that they remove only a small amount of tissue and in some cases, the amount of tissue removed might not be enough to both make a diagnosis and to perform more tests on the cancer cells that can help doctors choose anticancer drugs.

Fine needle aspiration (FNA) biopsy

The doctor uses a syringe with a very thin, hollow needle to withdraw (aspirate) cells and small fragments of tissue. A FNA biopsy may be done to check for cancer in the lymph nodes between the lungs.

Transtacheal FNA or transbronchial FNA is done by passing the needle through the wall of the trachea (windpipe) or bronchi (the large airways leading into the lungs) during bronchoscopy or endobronchial ultrasound (described below).

In some patients an FNA biopsy is done during an endoscopic esophageal ultrasound (described below) by passing the needle through the wall of the esophagus.

Core biopsy

A larger needle is used to remove one or more small cores of tissue. Samples from core biopsies are often preferred because they are larger than FNA biopsies.

Transthoracic needle biopsy

If the suspected tumor is in the outer part of the lungs, the biopsy needle can be put through the skin on the chest wall. The area where the needle is to be inserted may be numbed with local anesthesia first. The doctor then guides the needle into the area while looking at the lungs with either fluoroscopy (which is like a x-ray) or CT scan.

A possible complication of this procedure is that air may leak out of the lung at the biopsy site and into the space between the lung and the chest wall. This is called a **pneumothorax**. It can cause part of the lung to collapse and sometimes trouble breathing. If the air leak is small, it often gets better without any treatment. Large air leaks are treated by inserting a chest tube (a small tube into the chest space) which sucks out the air over a day or two, after which it usually heals on its own.

Bronchoscopy

[Bronchoscopy](#)⁹ can help the doctor find some tumors or blockages in the larger airways of the lungs, which can often be biopsied during the procedure.

Tests to find lung cancer spread in the chest

If lung cancer has been found, it's often important to know if it has spread to the lymph nodes in the space between the lungs (mediastinum) or other nearby areas. This can affect a person's treatment options. Several types of tests can be used to look for this cancer spread.

Endobronchial ultrasound

An [endobronchial ultrasound](#)¹⁰ can be used to see the lymph nodes and other structures in the area between the lungs if biopsies need to be taken in those areas.

Endoscopic esophageal ultrasound

An [endoscopic esophageal ultrasound](#)¹¹ goes down into the esophagus where it can show the nearby lymph nodes which may contain lung cancer cells. Biopsies of the abnormal lymph nodes can be taken at the same time as the procedure.

Mediastinoscopy and mediastinotomy

These procedures may be done to look more directly at and get samples from the structures in the mediastinum (the area between the lungs). The main difference between the two is in the location and size of the incision.

[Amediastinoscopy](#)¹² is a procedure that uses a lighted tube inserted behind the sternum (breast bone) and in front of the windpipe to look at and take tissue samples from the lymph nodes along the windpipe and the major bronchial tube areas. If some lymph nodes can't be reached by mediastinoscopy, a mediastinotomy may be done so the

surgeon can directly remove the biopsy sample. For this procedure, a slightly larger incision (usually about 2 inches long) between the left second and third ribs next to the breast bone is needed.

Thoracoscopy

[Thoracoscopy](#)¹³ can be done to find out if cancer has spread to the spaces between the lungs and the chest wall, or to the linings of these spaces. It can also be used to sample tumors on the outer parts of the lungs as well as nearby lymph nodes and fluid, and to assess whether a tumor is growing into nearby tissues or organs. This procedure is not often done just to diagnose lung cancer, unless other tests such as needle biopsies are unable to get enough samples for the diagnosis. Thoracoscopy can also be used as part of the treatment to remove part of a lung in some early-stage lung cancers. This type of operation, known as **video-assisted thoracic surgery (VATS)**, is described in [Surgery for Non-Small Cell Lung Cancer](#)¹⁴.

Lung function tests

Lung (or pulmonary) function tests (PFTs) are often done after lung cancer is diagnosed to see how well your lungs are working. This is especially important if surgery might be an option in treating the cancer. Surgery to remove lung cancer may mean removing part or all of a lung, so it's important to know how well your lungs are working beforehand. Some people with poor lung function (like those with lung damage from smoking) don't have enough undamaged lung to withstand removing even part of a lung. These tests can give the surgeon an idea of whether surgery is a good option, and if so, how much lung can safely be removed.

There are different types of PFTs, but they all basically have you breathe in and out through a tube that is connected to a machine that measures airflow.

Sometimes PFTs are coupled with a test called an **arterial blood gas**. In this test, blood is removed from an artery (instead of from a vein, like most other blood tests) so the amount of oxygen and carbon dioxide can be measured.

Lab tests of biopsy and other samples

Samples that have been collected during biopsies or other tests are sent to a pathology lab. A pathologist, a doctor who uses lab tests to diagnose diseases such as cancer, will look at the samples and may do other special tests to help better classify the cancer. (Cancers from other organs also can spread to the lungs. It's very important to find out

where the cancer started, because treatment is different depending on the type of cancer.)

The results of these tests are described in a pathology report, which is usually available within a week. If you have any questions about your pathology results or any diagnostic tests, talk to your doctor. If needed, you can get a second opinion of your pathology report by having your tissue samples sent to a pathologist at another lab.

For more information, see [Understanding Your Pathology Report](#)¹⁵.

Molecular tests for gene changes

In some cases, especially for non-small cell lung cancer (NSCLC), doctors may look for specific gene changes in the cancer cells that could mean certain [targeted drugs](#)¹⁶ might help treat the cancer.

- **EGFR** is a protein that appears in high amounts on the surface of 10% to 20% of NSCLC cells and helps them grow. Some drugs that target EGFR can be used to treat NSCLC with changes in the *EGFR* gene, which are more common in certain groups, such as non-smokers, women, and Asians. But these drugs don't seem to be as helpful in patients whose cancer cells have changes in the *KRAS* gene. Doctors now test NSCLC cells for changes in genes such as *EGFR* and *KRAS* to determine if these newer treatments are likely to be helpful.
- About 5% of NSCLCs have a change in the ***ALK*** gene. This change is most often seen in non-smokers (or light smokers) who have the adenocarcinoma subtype of NSCLC. Doctors may test cancers for changes in the *ALK* gene to see if drugs that target this change may help them.
- About 1% to 2% of NSCLCs have a rearrangement in the ***ROS1*** gene, which might make the tumor respond to certain targeted drugs. A similar percentage have a rearrangement in the ***RET*** gene. Certain drugs that target cells with *RET* gene changes might be options for treating these tumors.
- About 5% of NSCLCs have changes in the ***BRAF*** gene. Certain drugs that target cells with *BRAF* gene changes might be an option for treating these tumors.

These molecular tests can be done on tissue taken during a biopsy or surgery for lung cancer. If the biopsy sample is too small and all the molecular tests cannot be done, the testing may also be done on blood that is taken from a vein just like a regular blood draw. This blood contains the DNA from dead tumor cells found in the bloodstream of people with advanced lung cancer. Obtaining the tumor DNA through a blood draw is

sometimes called a "liquid biopsy" and can have advantages over a standard needle biopsy, which can carry risks like a pneumothorax (lung collapse) and shortness of breath.

Blood tests

Blood tests are not used to diagnose lung cancer, but they can help to get a sense of a person's overall health. For example, they can be used to help determine if a person is healthy enough to have surgery.

A **complete blood count (CBC)** looks at whether your blood has normal numbers of different types of blood cells. For example, it can show if you are anemic (have a low number of red blood cells), if you could have trouble with bleeding (due to a low number of blood platelets), or if you are at increased risk for infections (because of a low number of white blood cells). This test could be repeated regularly during treatment, as many cancer drugs can affect blood-forming cells of the bone marrow.

Blood chemistry tests can help find abnormalities in some of your organs, such as the liver or kidneys. For example, if cancer has spread to the bones, it might cause higher than normal levels of calcium and alkaline phosphatase.

Hyperlinks

1. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/signs-symptoms.html
2. www.cancer.org/cancer/lung-cancer/causes-risks-prevention/risk-factors.html
3. www.cancer.org/treatment/understanding-your-diagnosis/tests/x-rays-and-other-radiographic-tests.html
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Last Medical Review: October 1, 2019 Last Revised: October 1, 2019

Non-Small Cell Lung Cancer Stages

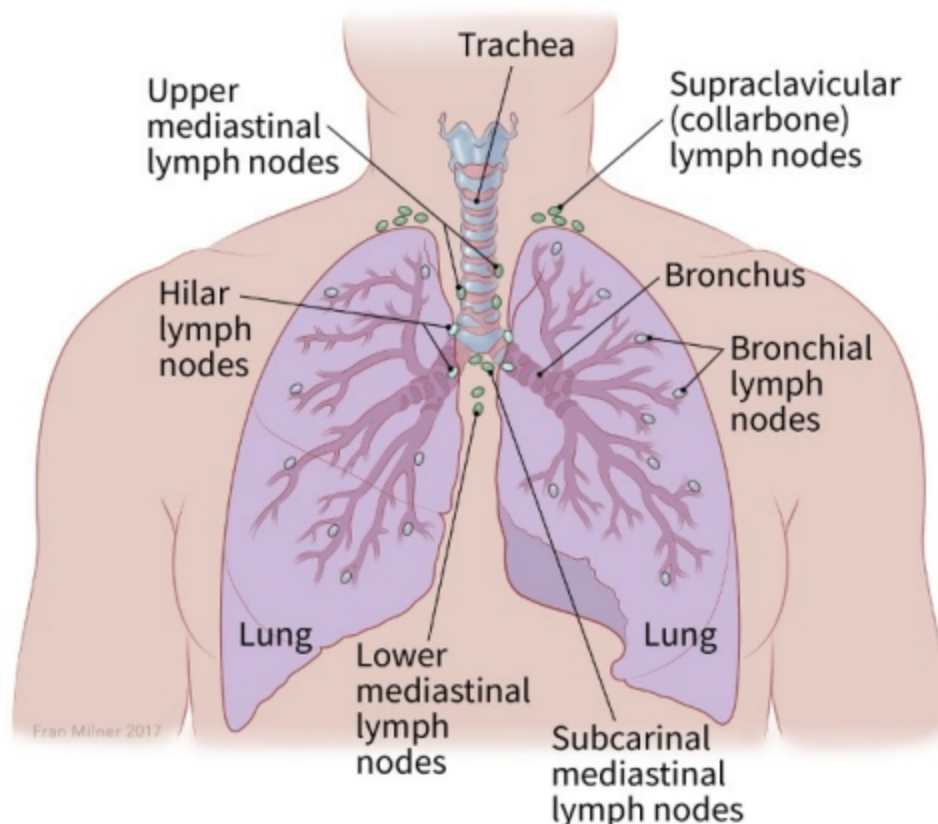
After someone is diagnosed with non-small cell lung cancer (NSCLC), doctors will try to figure out if it has spread, and if so, how far. This process is called staging. The stage of a cancer describes how much cancer is in the body. It helps determine how serious the cancer is and how best to [treat](#)¹ it. Doctors also use a cancer's stage when talking about survival statistics.

The earliest stage of NSCLC is stage 0 (also called carcinoma in situ, or CIS). Other stages range from I (1) through IV (4). As a rule, the lower the number, the less the cancer has spread. A higher number, such as stage IV, means cancer has spread more. And within a stage, an earlier letter (or number) means a lower stage. Although each person's cancer experience is unique, cancers with similar stages tend to have a similar outlook and are often treated in much the same way.

How is the stage determined?

The staging system most often used for NSCLC is the American Joint Committee on Cancer (AJCC) **TNM** system, which is based on 3 key pieces of information:

- The size and extent of the main **tumor (T)**: How large is the tumor? Has it grown into nearby structures or organs?
- The spread to nearby lymph **nodes (N)**: Has the cancer spread to nearby lymph nodes? (See image.)
- The spread (**metastasis**) to distant sites (**M**): Has the cancer spread to distant organs such as the brain, bones, adrenal glands, liver, or the other lung?



Numbers or letters after T, N, and M provide more details about each of these factors. Higher numbers mean the cancer is more advanced. Once a person's T, N, and M categories have been determined, this information is combined in a process called *stage grouping* to assign an overall stage. For more information, see [Cancer Staging²](#).

The system described below is the most recent version of the AJCC system, effective as of January 2018.

NSCLC is typically given a **clinical stage** based on the results of a physical exam, biopsy, and imaging tests (as described in [Tests for³Lung Cancer⁴](#)). If surgery is done, the **pathologic stage** (also called the **surgical stage**) is determined by examining tissue removed during the operation.

Staging for NSCLC can be complex, so ask your doctor to explain it to you in a way you understand.

Stages of non-small cell lung cancer

AJCC Stage	Stage grouping	Stage description*
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Occult (hidden) cancer	TX	The main tumor can't be assessed for some reason, or cancer cells are seen in a sample of sputum or other lung fluids, but the cancer isn't found with other tests, so its location can't be determined (TX). The cancer is not thought to have spread to nearby lymph nodes (N0) or to distant parts of the body (M0).
	N0	
	M0	
0	Tis	The tumor is found only in the top layers of cells lining the air passages, but it has not invaded deeper into other lung tissues (Tis). The cancer has not spread to nearby lymph nodes (N0) or to distant parts of the body (M0).
	N0	
	M0	
IA1	T1mi	The cancer is a minimally invasive adenocarcinoma . The tumor is no larger than 3 centimeters (cm) across, and the part that has invaded into deeper lung tissues is no more than ½ cm across. The cancer has not spread to nearby lymph nodes (N0) or to distant parts of the body (M0).
	N0	
	M0	
	OR	
IA1	T1a	The tumor is no larger than 1 cm across, it has not reached the membranes that surround the lungs, and it does not affect the main branches of the bronchi (T1a). The cancer has not spread to nearby lymph nodes (N0) or to distant parts of the body (M0).
	N0	
	M0	
IA2	T1b	The tumor is larger than 1 cm but no larger than 2 cm across. It has not reached the membranes that surround the lungs, and it does not affect the main branches of the bronchi (T1b). The cancer has not spread to nearby lymph nodes (N0) or to distant parts of the body (M0).
	N0	
	M0	
IA3	T1c	The tumor is larger than 2 cm but no larger than 3 cm across. It has not reached the membranes that surround the lungs, and it does not affect the main branches of the bronchi (T1c). The cancer has not spread to nearby lymph nodes (N0) or to distant parts of the body (M0).
	N0	
	M0	
IB	T2a	The tumor has one or more of the following features (T2a): <ul style="list-style-type: none"> • It is larger than 3 cm but not larger than 4 cm across. • It has grown into a main bronchus, but is not within 2 cm of the carina (the point where the windpipe splits into the left and right main bronchi) and it is not larger than 4 cm across.
	N0	
	M0	

		<ul style="list-style-type: none"> • It has grown into the visceral pleura (the membranes surrounding the lungs) and is not larger than 4 cm across. • It is partially clogging the airways (and is not larger than 4 cm across). <p>The cancer has not spread to nearby lymph nodes (N0) or to distant parts of the body (M0).</p>
IIA	T2b N0 M0	<p>The tumor has one or more of the following features (T2b):</p> <ul style="list-style-type: none"> • It is larger than 4 cm but not larger than 5 cm across. • It has grown into a main bronchus, but is not within 2 cm of the carina (the point where the windpipe splits into the left and right main bronchi) and it is larger than 4 cm but not larger than 5 cm across. • The tumor has grown into the visceral pleura (the membranes surrounding the lungs) and is larger than 4 cm but not larger than 5 cm across. • The tumor is partially clogging the airways (and is larger than 4 cm but not larger than 5 cm across). <p>The cancer has not spread to nearby lymph nodes (N0) or to distant parts of the body (M0).</p>
	T1a/T1b/T1c N1 M0	<p>The tumor is no larger than 3 cm across, has not grown into the membranes that surround the lungs, and does not affect the main branches of the bronchi (T1). It has spread to lymph nodes within the lung and/or around the area where the bronchus enters the lung (hilar lymph nodes). These lymph nodes are on the same side as the cancer (N1). The cancer has not spread to distant parts of the body (M0).</p>
	OR	
	T2a/T2b N1 M0	<p>The tumor has one or more of the following features (T2):</p> <ul style="list-style-type: none"> • It is larger than 3 cm but not larger than 5 cm across. • It has grown into a main bronchus, but is not within 2 cm of the carina (the point where the windpipe splits into the left and right main bronchi) and it is not larger than 5 cm across.

IIB		<ul style="list-style-type: none"> • It has grown into the visceral pleura (the membranes surrounding the lungs) and is not larger than 5 cm. • It is partially clogging the airways (and is not larger than 5 cm). <p>The cancer has also spread to lymph nodes within the lung and/or around the area where the bronchus enters the lung (hilar lymph nodes). These lymph nodes are on the same side as the cancer (N1). The cancer has not spread to distant parts of the body (M0).</p>
	OR	
	T3 N0 M0	<p>The tumor has one or more of the following features (T3):</p> <ul style="list-style-type: none"> • It is larger than 5 cm but not larger than 7 cm across. • It has grown into the chest wall, the inner lining of the chest wall (parietal pleura), the phrenic nerve, or membranes of the sac surrounding the heart (parietal pericardium). • There are 2 or more separate tumor nodules in the same lobe of a lung. <p>The cancer has not spread to nearby lymph nodes (N0) or distant parts of the body (M0).</p>
IIIA	T1a/T1b/T1c N2 M0	<p>The cancer is no larger than 3 cm across, has not grown into the membranes that surround the lungs, and does not affect the main branches of the bronchi (T1). The cancer has spread to lymph nodes around the carina (the point where the windpipe splits into the left and right bronchi) or in the space between the lungs (mediastinum). These lymph nodes are on the same side as the main lung tumor (N2). The cancer has not spread to distant parts of the body (M0).</p>
	OR	
	T2a/T2b N2 M0	<p>The tumor has one or more of the following features (T2):</p> <ul style="list-style-type: none"> • It is larger than 3 cm but not larger than 5 cm across. • It has grown into a main bronchus, but is not within 2 cm of the carina (the point where the windpipe splits into the left and right main bronchi) and it is not larger than 5 cm

		<p>across.</p> <ul style="list-style-type: none"> • It has grown into the visceral pleura (the membranes surrounding the lungs) and is not larger than 5 cm. • It is partially clogging the airways (and is not larger than 5 cm). <p>The cancer has spread to lymph nodes around the carina (the point where the windpipe splits into the left and right bronchi) or in the space between the lungs (mediastinum). These lymph nodes are on the same side as the main lung tumor (N2). The cancer has not spread to distant parts of the body (M0).</p>
OR		
	<p>T3 N1 M0</p>	<p>The tumor has one or more of the following features (T3):</p> <ul style="list-style-type: none"> • It is larger than 5 cm but not larger than 7 cm across. • It has grown into the chest wall, the inner lining of the chest wall (parietal pleura), the phrenic nerve, or membranes of the sac surrounding the heart (parietal pericardium). • There are 2 or more separate tumor nodules in the same lobe of a lung. <p>The cancer has also spread to lymph nodes within the lung and/or around the area where the bronchus enters the lung (hilar lymph nodes). These lymph nodes are on the same side as the cancer (N1). The cancer has not spread to distant parts of the body (M0).</p>
OR		
	<p>T4 N0 or N1 M0</p>	<p>The tumor has one or more of the following features (T4):</p> <ul style="list-style-type: none"> • It is larger than 7 cm across. • It has grown into the space between the lungs (mediastinum), the heart, the large blood vessels near the heart (such as the aorta), the windpipe (trachea), the tube connecting the throat to the stomach (esophagus), the thin muscle separating the chest from the abdomen (diaphragm), the backbone, or the carina. • There are 2 or more separate tumor nodules in different

		lobes of the same lung. The cancer may or may not have spread to lymph nodes within the lung and/or around the area where the bronchus enters the lung (hilar lymph nodes). Any affected lymph nodes are on the same side as the cancer (N0 or N1). The cancer has not spread to distant parts of the body (M0).
IIIB	T1a/T1b/T1c N3 M0	The cancer is no larger than 3 cm across, has not grown into the membranes that surround the lungs, and does not affect the main branches of the bronchi (T1). The cancer has spread to lymph nodes near the collarbone on either side of the body, and/or has spread to hilar or mediastinal lymph nodes on the other side of the body from the main tumor (N3). The cancer has not spread to distant parts of the body (M0).
	OR	
	T2a/T2b N3 M0	The tumor has one or more of the following features (T2): <ul style="list-style-type: none"> • It is larger than 3 cm but not larger than 5 cm across. • It has grown into a main bronchus, but is not within 2 cm of the carina (the point where the windpipe splits into the left and right main bronchi) and it is not larger than 5 cm across. • It has grown into the visceral pleura (the membranes surrounding the lungs) and is not larger than 5 cm. • It is partially clogging the airways (and is not larger than 5 cm). <p>The cancer has spread to lymph nodes near the collarbone on either side of the body, and/or has spread to hilar or mediastinal lymph nodes on the other side of the body from the main tumor (N3). The cancer has not spread to distant parts of the body (M0).</p>
	OR	
	T3 N2	The tumor has one or more of the following features (T3): <ul style="list-style-type: none"> • It is larger than 5 cm but not larger than 7 cm across. • It has grown into the chest wall, the inner lining of the chest

	<p>M0</p>	<p>wall (parietal pleura), the phrenic nerve, or membranes of the sac surrounding the heart (parietal pericardium).</p> <ul style="list-style-type: none"> • There are 2 or more separate tumor nodules in the same lobe of a lung. <p>The cancer has spread to lymph nodes around the carina (the point where the windpipe splits into the left and right bronchi) or in the space between the lungs (mediastinum). These lymph nodes are on the same side as the main lung tumor (N2). The cancer has not spread to distant parts of the body (M0).</p>
<p>OR</p>		
	<p>T4 N2 M0</p>	<p>The tumor has one or more of the following features (T4):</p> <ul style="list-style-type: none"> • It is larger than 7 cm across. • It has grown into the space between the lungs (mediastinum), the heart, the large blood vessels near the heart (such as the aorta), the windpipe (trachea), the tube connecting the throat to the stomach (esophagus), the thin muscle separating the chest from the abdomen (diaphragm), the backbone, or the carina (the point where the windpipe splits into the left and right main bronchi). • There are 2 or more separate tumor nodules in different lobes of the same lung. <p>The cancer has spread to lymph nodes around the carina (the point where the windpipe splits into the left and right bronchi) or in the space between the lungs (mediastinum). These lymph nodes are on the same side as the main lung tumor (N2). The cancer has not spread to distant parts of the body (M0).</p>
<p>IIIC</p>	<p>T3 N3 M0</p>	<p>The tumor has one or more of the following features (T3):</p> <ul style="list-style-type: none"> • It is larger than 5 cm but not larger than 7 cm across. • It has grown into the chest wall, the inner lining of the chest wall (parietal pleura), the phrenic nerve, or membranes of the sac surrounding the heart (parietal pericardium). • There are 2 or more separate tumor nodules in the same lobe of a lung.

		The cancer has spread to lymph nodes near the collarbone on either side of the body, and/or has spread to hilar or mediastinal lymph nodes on the other side of the body from the main tumor (N3). The cancer has not spread to distant parts of the body (M0).
	OR	
	T4 N3 M0	<p>The tumor has one or more of the following features (T4):</p> <ul style="list-style-type: none"> • It is larger than 7 cm across. • It has grown into the space between the lungs (mediastinum), the heart, the large blood vessels near the heart (such as the aorta), the windpipe (trachea), the tube connecting the throat to the stomach (esophagus), the thin muscle separating the chest from the abdomen (diaphragm), the backbone (spine), or the carina (the point where the windpipe splits into the left and right main bronchi). • There are 2 or more separate tumor nodules in different lobes of the same lung. <p>The cancer has spread to lymph nodes near the collarbone on either side of the body, and/or has spread to hilar or mediastinal lymph nodes on the other side of the body from the main tumor (N3). The cancer has not spread to distant parts of the body (M0).</p>
IVA	Any T Any N M1a	<p>The cancer can be any size and may or may not have grown into nearby structures (any T). It may or may not have reached nearby lymph nodes (any N). In addition, any of the following is true (M1a):</p> <ul style="list-style-type: none"> • The cancer has spread to the other lung. • Cancer cells are found in the fluid around the lung (called a malignant pleural effusion). • Cancer cells are found in the fluid around the heart (called a malignant pericardial effusion).
	OR	
	Any T	The cancer can be any size and may or may not have grown

	Any N M1b	into nearby structures (any T). It may or may not have reached nearby lymph nodes (any N). It has spread as a single tumor outside of the chest, such as to a distant lymph node or an organ such as the liver, bones, or brain (M1b).
IVB	Any T Any N M1c	The cancer can be any size and may or may not have grown into nearby structures (any T). It may or may not have reached nearby lymph nodes (any N). It has spread as more than one tumor outside the chest, such as to distant lymph nodes and/or to other organs such as the liver, bones, or brain (M1c).

*The following additional categories are not listed in the table above:

- **T0:** There is no evidence of a primary tumor.
- **NX:** Nearby lymph nodes cannot be assessed due to lack of information.

Hyperlinks

1. www.cancer.org/cancer/non-small-cell-lung-cancer/treating.html
2. www.cancer.org/treatment/understanding-your-diagnosis/staging.html
3. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/how-diagnosed.html
4. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/how-diagnosed.html

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Last Medical Review: October 1, 2019 Last Revised: October 1, 2019

Small Cell Lung Cancer Stages

After someone is diagnosed with small cell lung cancer (SCLC), doctors will try to figure out if it has spread, and if so, how far. This process is called **staging**. The stage of a

cancer describes how much cancer is in the body. It helps determine how serious the cancer is and how best to treat it. Doctors also use a cancer's stage when talking about survival statistics.

The stage of SCLC is based on the results of physical exams, biopsies, imaging tests, and any other tests that have been done (as described in [Tests for Lung Cancer¹](#)).

Limited versus extensive stage

For treatment purposes, most doctors use a 2-stage system that divides SCLC into limited stage and extensive stage. For limited stage cancer, a person might benefit from more aggressive treatments such as [chemotherapy²](#) combined with [radiation therapy³](#) to try to cure the cancer. For extensive stage disease, chemotherapy alone is likely to be a better option to control (not cure) the cancer.

Limited stage

This means that the cancer is only on one side of the chest and can be treated with a single radiation field. This generally includes cancers that are only in one lung (unless tumors are widespread throughout the lung), and that might also have reached the lymph nodes on the same side of the chest.

Cancer in lymph nodes above the collarbone (called **supraclavicular nodes**) might still be considered limited stage as long as they are on the same side of the chest as the cancer. Some doctors also include lymph nodes at the center of the chest (**mediastinal lymph nodes**) even when they are closer to the other side of the chest.

What is important is that the cancer is confined to an area that is small enough to be treated with radiation therapy in one “port” or one treatment area. Only about 1 out of 3 people with SCLC have limited stage cancer when it is first found.

Extensive stage

This describes cancers that have spread widely throughout the lung, to the other lung, to lymph nodes on the other side of the chest, or to other parts of the body (including the bone marrow). Many doctors consider SCLC that has spread to the fluid around the lung to be extensive stage as well. About 2 out of 3 people with SCLC have extensive disease when their cancer is first found.

The TNM staging system

A more formal system to describe the growth and spread of lung cancer is the American Joint Committee on Cancer (AJCC) **TNM** staging system, which is based on 3 key pieces of information:

- The size and extent of the main **tumor (T)**: How large is the tumor? Has it grown into nearby structures or organs?
- The spread to nearby (regional) lymph **nodes (N)**: Has the cancer spread to nearby lymph nodes?
- The spread (**metastasis (M)**) to other organs of the body: Has the cancer spread to distant organs such as the brain, bones, adrenal glands, liver, or the other lung?

Numbers or letters appear after T, N, and M to provide more details about each of these factors. Higher numbers mean the cancer is more advanced. Once the T, N, and M categories have been determined, this information is combined in a process called *stage grouping*, to assign an overall stage. For more information, see [Cancer Staging](#)⁴.

In the TNM system, the earliest stage is stage 0 (also called *carcinoma in situ*, or CIS). The other main stages range from I (1) through IV (4). Some of these stages are broken down further with letters or numbers. As a rule, the lower the stage number, the less the cancer has spread. A higher number, such as stage IV, means cancer has spread more. And within a stage, an earlier letter (or number) means a lower stage.

The same TNM staging system is used for both SCLC and non-small cell lung cancer (NSCLC), although it's generally not as important for SCLC. For more detailed information about this system, see [Non-Small Cell Lung Cancer Stages](#)⁵. Staging with the TNM system can be complex, so if your health care team is using it, ask them to explain it to you in a way you understand.

Hyperlinks

1. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/how-diagnosed.html
2. www.cancer.org/cancer/lung-cancer/treating-small-cell/chemotherapy.html
3. www.cancer.org/cancer/lung-cancer/treating-small-cell/radiation-therapy.html
4. www.cancer.org/treatment/understanding-your-diagnosis/staging.html
5. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/staging-nsclc.html

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Hann CL, Wu A, Rekhman N, Rudin CM. Chapter 49: Small cell and Neuroendocrine Tumors of the Lung. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 11th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2019.

Last Medical Review: October 1, 2019 Last Revised: October 1, 2019

Lung Cancer Survival Rates

Survival rates can give you an idea of what percentage of people with the same type and stage of cancer are still alive a certain amount of time (usually 5 years) after they were diagnosed. They can't tell you how long you will live, but they may help give you a better understanding of how likely it is that your treatment will be successful.

Keep in mind that survival rates are estimates and are often based on previous outcomes of large numbers of people who had a specific cancer, but they can't predict what will happen in any particular person's case. These statistics can be confusing and may lead you to have more questions. Talk with your doctor about how these numbers may apply to you, as he or she is familiar with your situation.

What is a 5-year relative survival rate?

A **relative survival rate** compares people with the same type and stage of cancer to people in the overall population. For example, if the **5-year relative survival rate** for a specific stage of lung cancer is 60%, it means that people who have that cancer are, on

average, about 60% as likely as people who don't have that cancer to live for at least 5 years after being diagnosed.

Where do these numbers come from?

The American Cancer Society relies on information from the SEER* database, maintained by the National Cancer Institute (NCI), to provide survival statistics for different types of cancer.

The SEER database tracks 5-year relative survival rates for non-small cell lung cancer (NSCLC) and small cell lung cancer (SCLC) in the United States, based on how far the cancer has spread. The SEER database, however, does not group cancers by [AJCC TNM stages](#)¹ (stage 1, stage 2, stage 3, etc.). Instead, it groups cancers into localized, regional, and distant stages:

- **Localized:** There is no sign that the cancer has spread outside of the lung.
- **Regional:** The cancer has spread outside the lung to nearby structures or lymph nodes.
- **Distant:** The cancer has spread to distant parts of the body, such as the brain, bones, liver, or the other lung.

5-year relative survival rates for non-small cell lung cancer

(Based on people diagnosed with NSCLC between 2008 and 2014.)

SEER stage	5-year relative survival rate
Localized	60%
Regional	33%
Distant	6%
All SEER stages combined	23%

5-year relative survival rates for small cell lung cancer

(Based on people diagnosed with SCLC between 2008 and 2014.)

SEER stage	5-year relative survival rate
Localized	29%
Regional	15%
Distant	3%
All SEER stages combined	6%

Understanding the numbers

- **These numbers apply only to the stage of the cancer when it is first diagnosed.** They do not apply later on if the cancer grows, spreads, or comes back after treatment.
- **These numbers don't take everything into account.** Survival rates are grouped based on how far the cancer has spread. But other factors, such as the [subtype of NSCLC²](#), [gene changes in the cancer cells³](#), your age and overall health, and how well the cancer responds to treatment, can also affect your outlook.
- **People now being diagnosed with NSCLC or SCLC may have a better outlook than these numbers show.** Treatments improve over time, and these numbers are based on people who were diagnosed and treated at least five years earlier.

*SEER = Surveillance, Epidemiology, and End Results

Hyperlinks

1. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/staging-nsclc.html
2. www.cancer.org/cancer/lung-cancer/about/what-is.html
3. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/how-diagnosed.html

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Last Medical Review: October 1, 2019 Last Revised: October 1, 2019

Questions to Ask About Lung Cancer

It's important to have honest, open discussions with your cancer care team. They want to answer all your questions, so that you can make informed treatment and life decisions. For instance, consider these questions:

When you're told you have lung cancer

- What [kind of lung cancer](#)¹ do I have?
- Where exactly is the cancer? Has it spread beyond where it started?
- What is the [stage](#)² of my cancer, and what does that mean in my case?
- Will I need any other [tests](#)³ before we can decide on treatment?
- Should my blood or tumor tissue be sent for [molecular testing](#)⁴?
- Has the cancer been checked for gene changes that could help you choose my treatment options?
- Do I need to see any other doctors or health professionals?
- If I'm concerned about the costs and insurance coverage for my diagnosis and treatment, who can help me?

When deciding on a treatment plan

- How much experience do you have treating this type of cancer?
- What are my treatment choices?
- What do you recommend and why?
- What is the goal of treatment?
- Should I get a [second opinion](#)⁵? How do I do that? Can you recommend someone?
- What are the chances my cancer can be cured with these treatment options?
- How quickly do I need to decide on treatment?

- What should I do to be ready for treatment?
- How long will my treatment last? What will treatment be like? Where will my treatment be done?
- What are the risks and side effects with the treatments you suggest? How long are they likely to last?
- Will treatment affect my daily activities?
- What would my options be if the treatment doesn't work or if the cancer [comes back](#)⁶ (recur) after treatment?

During treatment

Once treatment begins, you'll need to know what to expect and what to look for. Not all of these questions may apply to you, but asking the ones that do may be helpful.

- How will we know if the treatment is working?
- Is there anything I can do to help manage [side effects](#)⁷?
- What symptoms or side effects should I tell you about right away?
- How can I reach you on nights, holidays, or weekends?
- Do I need to change what I eat during treatment?
- Are there any limits on what I can do?
- Can you suggest a mental health professional I can see if I start to feel [overwhelmed, depressed, or distressed](#)⁸?

After treatment

- Are there any limits on what I can do?
- What symptoms should I watch for?
- What kind of exercise should I do now?
- What type of follow-up will I need after treatment?
- How often will I need to have follow-up exams and imaging tests?
- Will I need any blood tests?
- How will we know if the cancer has come back? What should I watch for?
- What will my options be if the cancer comes back?

Along with these sample questions, be sure to write down some of your own. For instance, you might want more information about recovery times. Or you might want to

ask if you qualify for a [clinical trial](#)⁹.

Doctors aren't the only ones who can give you information. Other health care professionals, such as nurses and social workers, can also answer some of your questions. You can find out more about speaking with your health care team in [The Doctor-Patient Relationship](#)¹⁰.

Hyperlinks

1. www.cancer.org/cancer/lung-cancer/about.html
2. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/staging-nsclc.html
3. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/how-diagnosed.html
4. www.cancer.org/cancer/lung-cancer/detection-diagnosis-staging/how-diagnosed.html
5. www.cancer.org/treatment/finding-and-paying-for-treatment/choosing-your-treatment-team/seeking-a-second-opinion.html
6. www.cancer.org/treatment/survivorship-during-and-after-treatment/understanding-recurrence.html
7. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects.html
8. www.cancer.org/treatment/treatments-and-side-effects/emotional-side-effects.html
9. www.cancer.org/treatment/treatments-and-side-effects/clinical-trials.html
10. www.cancer.org/treatment/finding-and-paying-for-treatment/choosing-your-treatment-team/the-doctor-patient-relationship.html

Last Medical Review: October 1, 2019 Last Revised: October 1, 2019

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