VICTORIAN LUNG CANCER REGISTRY

ANNUAL REPORT 2024

MONASH University

VLCR Victorian Lung Cancer Registry

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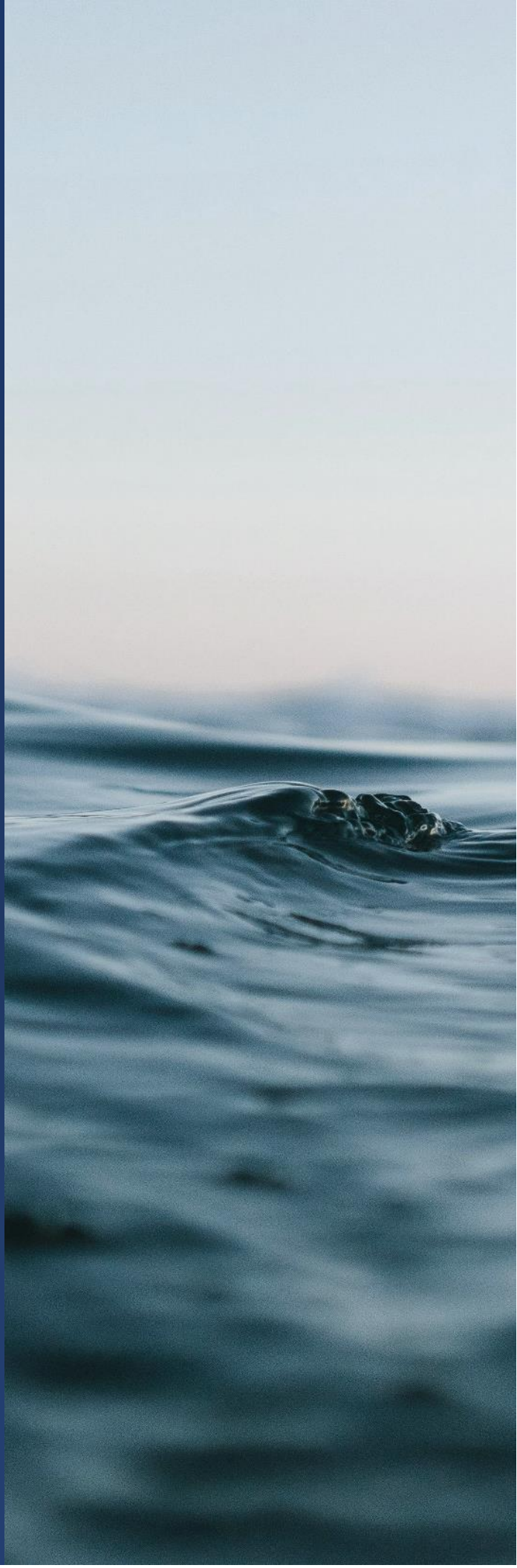

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Foreword

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Coordinating Principal Investigator, Steering Committee Chairman
Victorian Lung Cancer Registry

It is with great pleasure that I present the Victorian Lung Cancer Registry (VLCR) 2024 Annual Report. Lung cancer remains a major disease burden in Victoria and the greatest contributor to Australian cancer mortality. Management opportunities are evolving rapidly and requires a complex and multidisciplinary approach to ensure optimal care and outcomes. The evaluation of these complex patterns of care has the capacity to inform better clinical decision making, support clinicians and hospitals in continuous quality improvement, and improve outcomes for Victorian patients.

The VLCR established a collaboration with clinicians, health services, researchers and patients in 2011, to capture clinical process and outcome measures, reflecting the quality of care delivered to patients diagnosed with lung cancer in Victoria, currently describing over 22,000 registrations. This 2024 Annual Report includes snapshots of outcome data from 19 participating health services, including 50 participating hospitals aiming to capture all patients newly diagnosed with a primary lung cancer in stakeholder hospitals in Victoria, in the 2024 calendar year. VLCR reports provide institutional quality of care benchmarking, identifying significant variation in practice from clinical practice guidelines, representing evidence-practice gaps and potential unwarranted clinical variation in processes and outcomes. This report provides a framework within which it is possible to compare hospital performance with peer and state outcomes for reported measures. The definition of such variation may help identify opportunities for improvement within a hospital and hopefully reflect improvements already undertaken within health services.

In 2024, we saw a number of changes, including migration to the new REDCap data collection platform, data collector training and novel data analyses. Staff changes have included new arrivals including Professor Zoe McQuilten, Professor Nik Zeps, Jessie Zeng and Krupa Krishnaprasad. I would like to acknowledge and thank the participants enrolled in the Registry and the members of the VLCR Steering and Management Committees, who generously volunteer their time to support this important project. At each of the participating sites, there are also clinical staff, data collectors and other hospital staff who make important contributions to VLCR and I thank them for their efforts. I would like to express our gratitude to the Monash University team, VLCR data collectors and the Cancer Research Program Staff. Special thanks go to the VLCR Senior Project Officer Jessie Zeng, Project Manager Sanuki Tissera, and Data Analyst Mike Lloyd, who have invested significant work in this report.

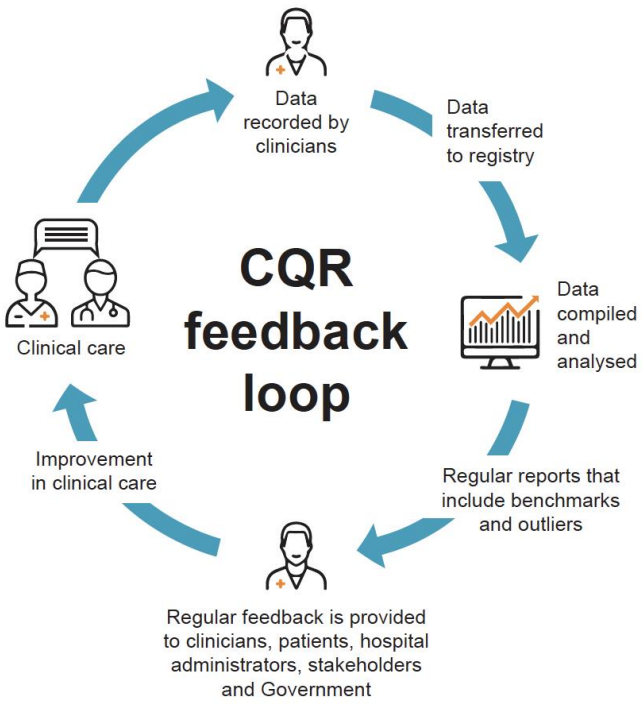
The information in this report describes the progress of the VLCR and the commitment from clinical stakeholders to best practice and improving patient outcomes. The VLCR continues to develop and improve and we are committed to delivering better and more complete reports each year to fulfil the needs of various stakeholders. Your feedback and participation in this endeavour is much appreciated.

Executive Summary

Lung cancer is the fifth most common cancer in Australia, with approximately 15,100 new diagnoses in 2024. It carries the highest mortality burden and is responsible for over 8,500 deaths (17% of all cancer deaths). By capturing real-world data from participating health services on newly diagnosed primary lung cancer, the VLCR provides insights into the quality of care delivered and enhances understanding of clinical and survival outcomes for patients, families, government bodies, policymakers, clinicians, researchers and other key stakeholders.

The 2024 VLCR Annual Report highlights significant achievements in the collection and reporting of lung cancer data across 19 health services and 51 hospitals. It provides an overview of participant demographics, disease summary, population-based patterns of care and state-wide benchmarking for a set of clinical quality indicators. These indicators allow health services to compare their performance with other participating health services in Victoria, identifying both areas of excellence and opportunities for improvement. These findings support health services in aligning clinical practice with established guidelines and best practice, ultimately benefiting Victorian patients.

Over the past year, the VLCR has continued its efforts to expand governance structures for greater national representation, strengthen interstate collaborations, enhance engagement in national initiatives, streamline data collection and reporting processes, and extend data coverage to other states, including health services in New South Wales and Tasmania. The VLCR remains committed to continuous improvement in lung cancer management and outcomes. We sincerely thank all the participants, clinicians, and stakeholders involved. Through these collective efforts, we strive to advance the quality of lung cancer care across and beyond Victoria.



Clinical quality registries collect, analyse and report information about the care and outcomes being delivered by health service organisations, and serve as a fundamental driver of ongoing improvements in the safety and quality of the care provided to patients and disease communities.

Research Methodology and Governance

Following notification of all new lung cancer cases from participating health services, patients are screened for eligibility by trained data collectors ***(Figure 1)***.

Inclusion criteria: All new cases of primary lung cancer.

Exclusion criteria: Patients who present with secondary lung cancer, mesothelioma, or disease diagnosed before the health service-specified commencement date and those who have contacted the VLCR to opt out.

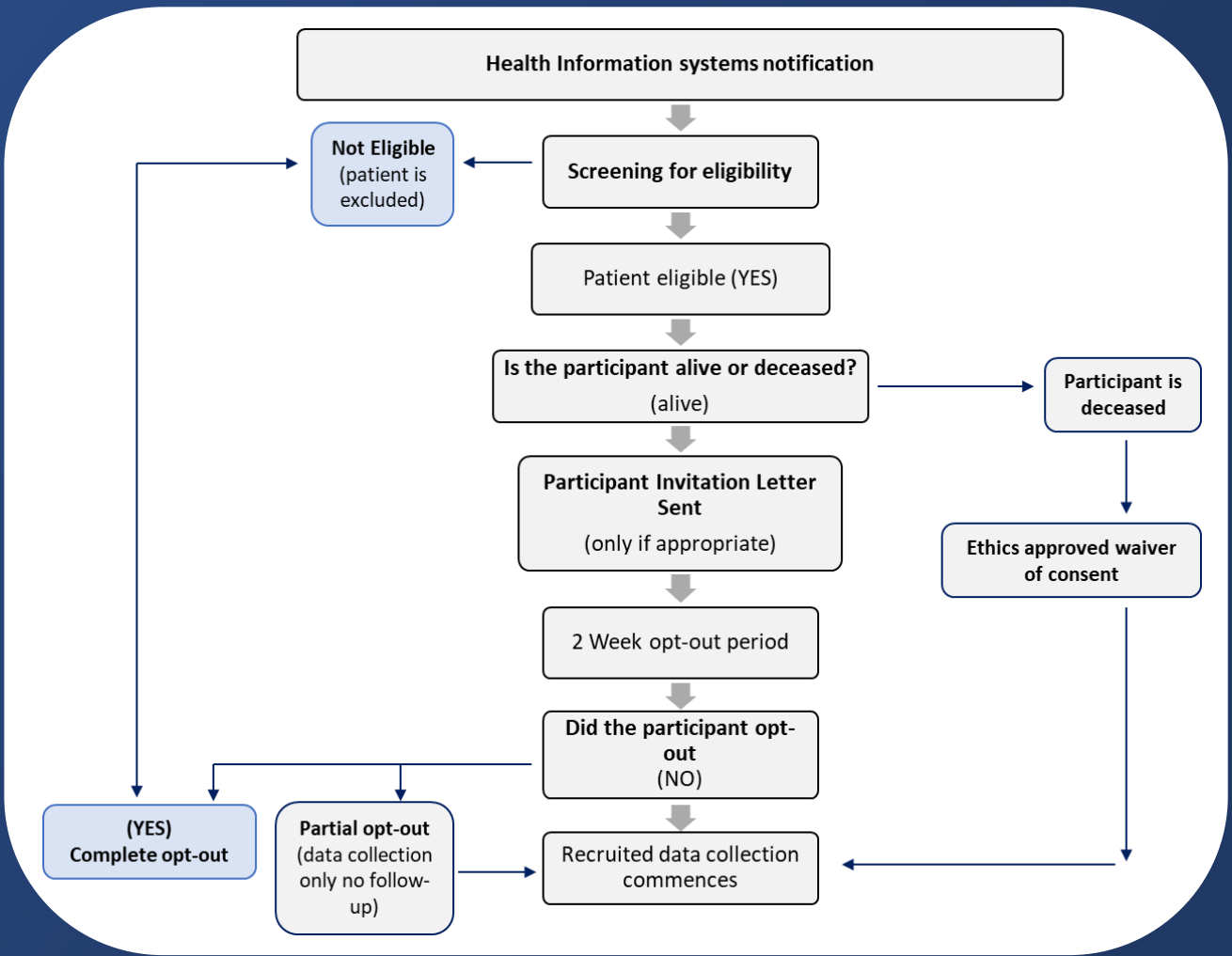
What information do we collect?

Referral & Diagnosis Information
- Referral date and type
- Diagnosis date
- Diagnostic procedure (e.g., biopsy, PET scan)

Cancer Information
- Cancer stage
- Type of lung cancer
- Morphology
- Comorbidities
- Molecular profile

Treatment Information
- Treatment planning
- Surgery and pathology
- Systemic anti-cancer therapy
- Radiation therapy

Figure 1: Workflow of the VLCR



Registry Engagement

By the end of 2025, the VLCR has data collection occurring at 51 public and private hospitals across Australia, with ongoing plans for expansion***, Table 1***.

Table 1: Participating health services at the end of 2025

Victoria

- Albury Wodonga Health
- Alfred Health
- Austin Health
- Barwon Health
- Bendigo Health
- Cabrini Health
- Eastern Health
- Epworth Healthcare
- Genesis Care
- Goulburn Valley Health
- Grampians Health
- Latrobe Regional Health
- Monash Health
- Northern Health
- Peninsula Health
- Peter MacCallum Cancer Centre
- Royal Melbourne Hospital
- St Vincent's Hospital
- St Vincent's Private Hospital
- Western Health

Tasmania

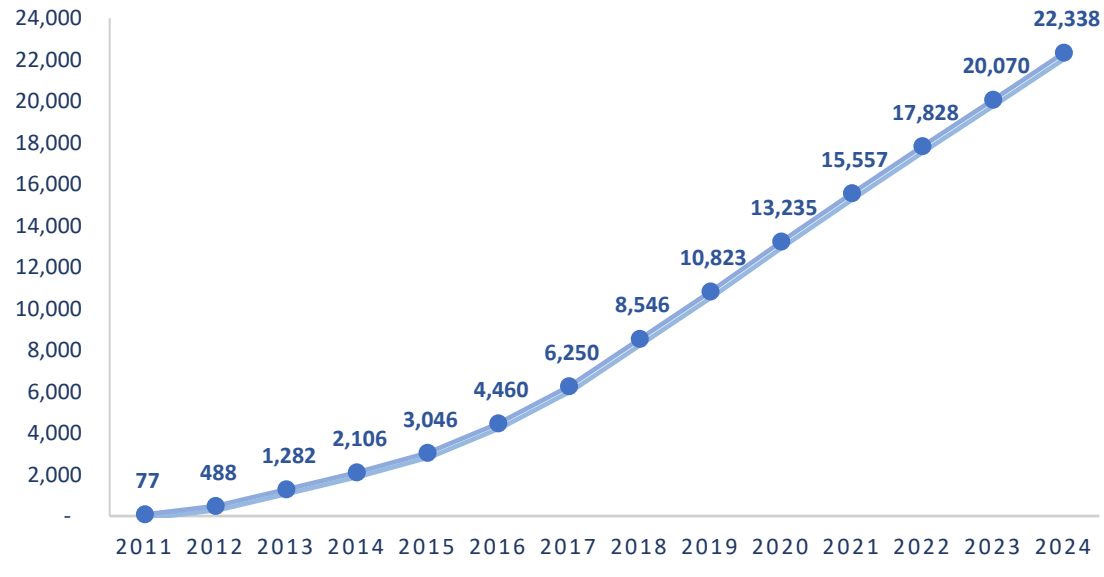
- Royal Hobart Hospital
- Launceston Hospital (recruiting)

New South Wales

- Calvary Mater Newcastle (recruiting)

A total of **22,338** participants were recruited to the VLCR between registry commencement in 2011 and the end of 2024 ***(Figure 2)***. The opt-out rate for the VLCR has remained low, ranging from 2-3%.

Figure 2: Cumulative number of participants recruited into the VLCR from 2011 to 2024



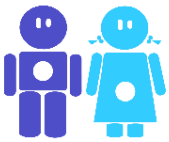
Overview and Key Findings

New registrations:
2,268

Opted out:
58

Median age:
71 years

53% Male
47% Female



Demographics

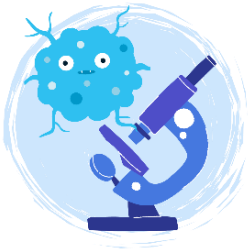
43% born overseas

81% spoke English as preferred language

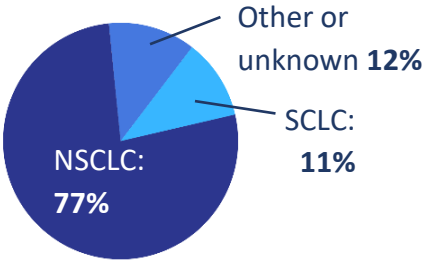
73% of patients live in metropolitan Victoria

64% had low or medium socioeconomic status

Lung Cancer Type



90% had a tissue confirmed diagnosis of lung cancer via histology or cytology



Management and Treatment

74% discussed at a multidisciplinary meeting

68% had a diagnosis within 28 days of referral

33% had supportive care screening completed

33% had treatment within 14 days of diagnosis

Overview by Cancer Type

Non-small Cell Lung Cancer (NSCLC)

Demographics

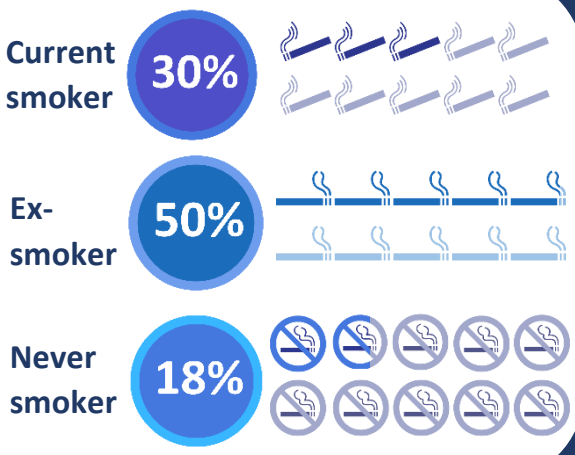
53% male, **47%** female

1.2% were Aboriginal and/or Torres Strait Islander

Median age was **71** years

ECOG score 0-1 for **58%** of patients

Smoking Status



Smoking status unknown for 2.6%

Clinical Stage

33%

18%

49%

17%

Treatment

Lung cancer resection: **33%**

Systemic anti-cancer therapy: **46%**

Radiation therapy: **37%**

No treatment: **14%**

Overview by Cancer Type

Small Cell Lung Cancer (SCLC)

Demographics

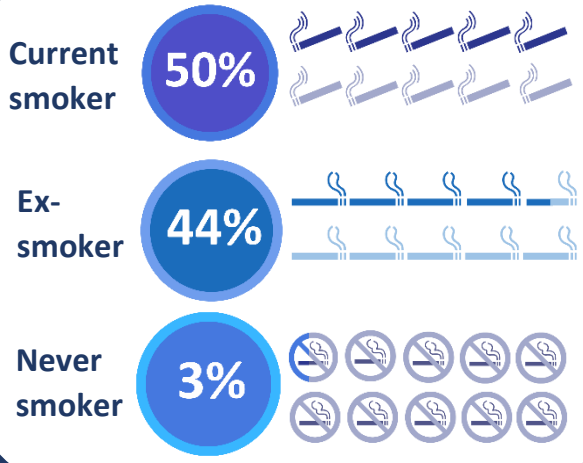
54% male, **46%** female

1.2% were Aboriginal and/or Torres Strait Islander

Median age was **69** years

ECOG score 0-1 for **52%** of patients

Smoking Status



Smoking status unknown for 3.5%

Clinical Stage

Limited Disease 23%

Extensive Disease 77%

Unknown Stage 5%

Treatment

Lung cancer resection: **2%**

Systemic anti-cancer therapy: **74%**

Radiation therapy: **37%**

No treatment: **23%**

Non-small Cell Lung Cancer (NSCLC)

Demographics and Disease

38% of participants diagnosed with NSCLC were aged 70 to 79 years and 17% of participants were 80 years or older ***(Figure 3)***. The most common type of NSCLC was adenocarcinoma (69%) followed by squamous cell carcinoma (21%) ***(Figure 4)***.

Figure 3: Age of participants with NSCLC

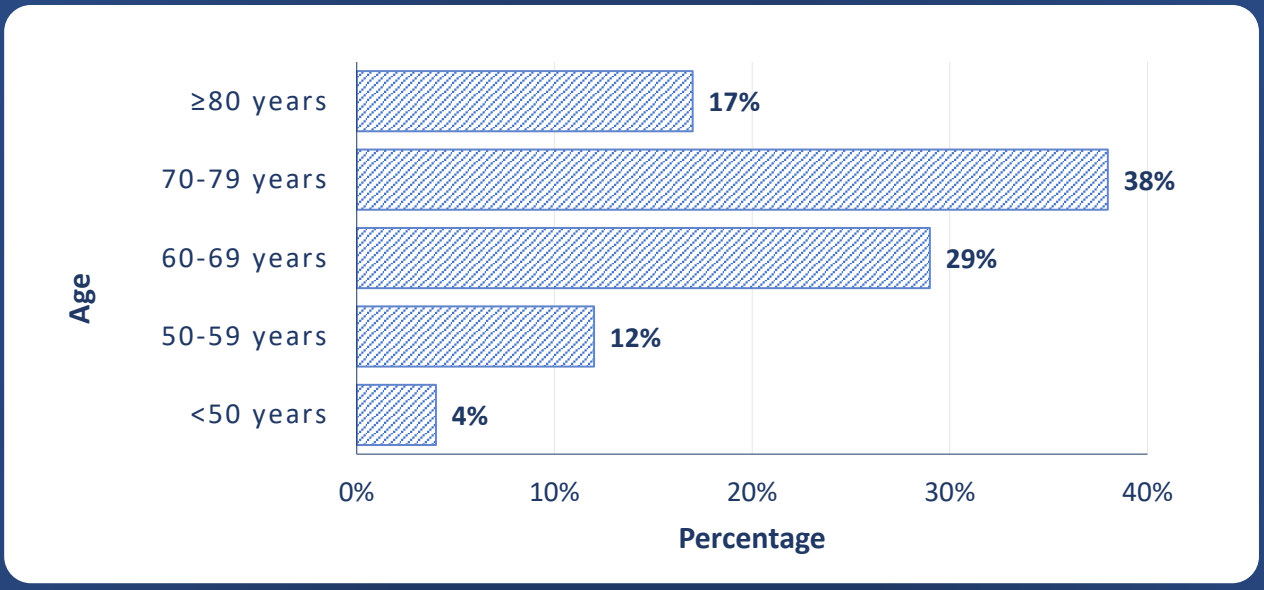
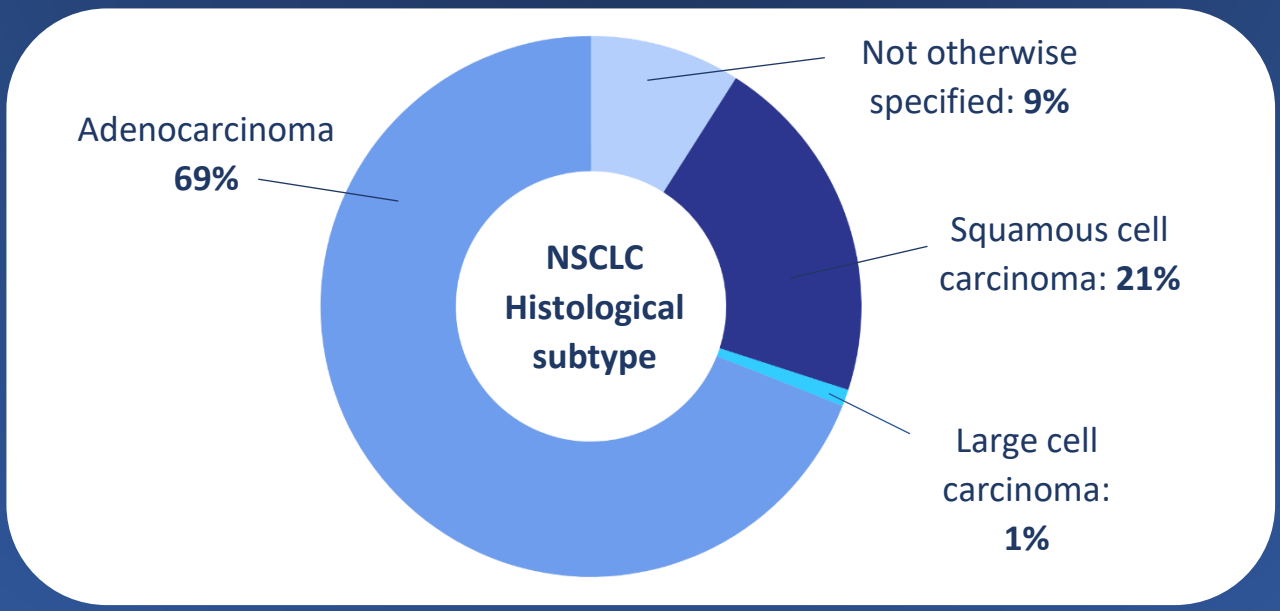
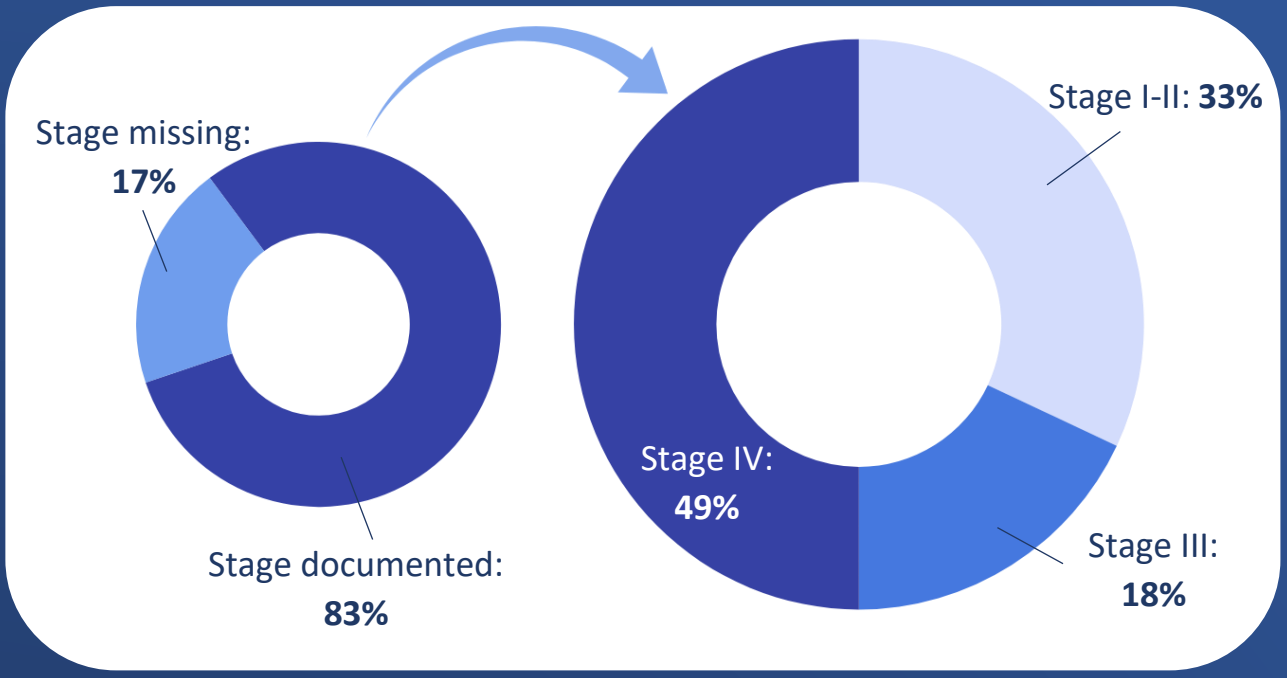


Figure 4: NSCLC Histological Subtype



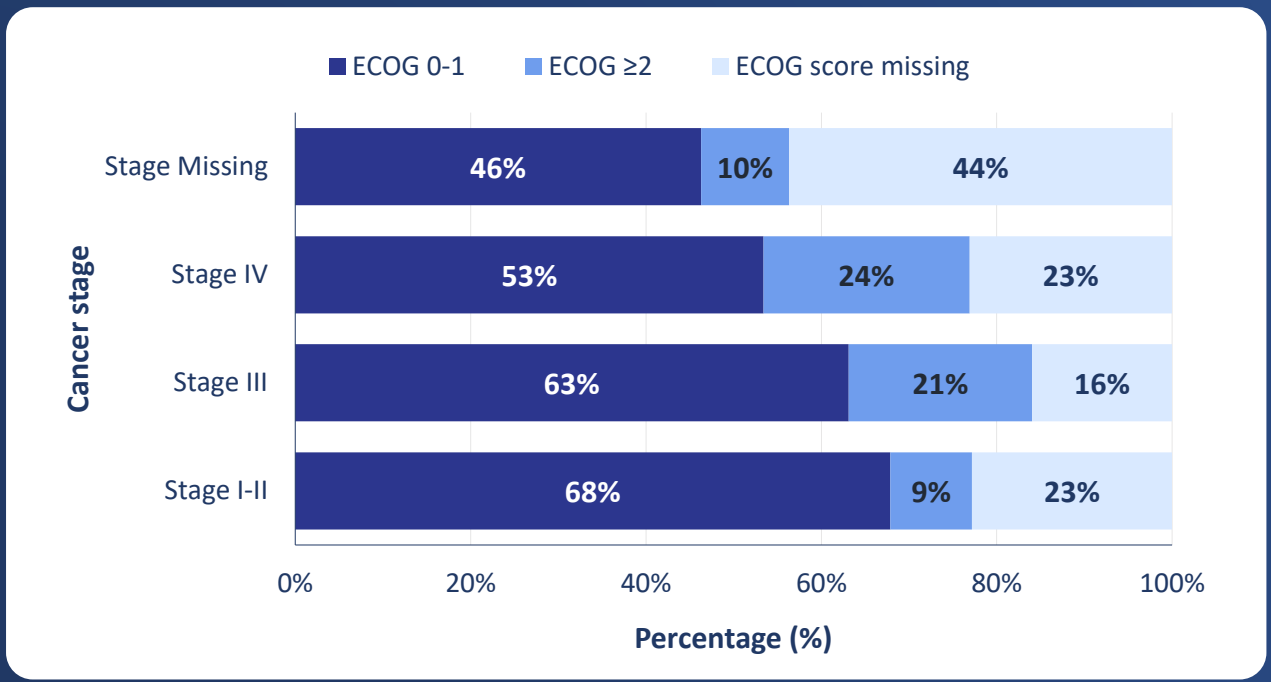
83% of participants had clinical stage documented, with the highest proportion of participants diagnosed with Stage IV NSCLC (49%) and 33% were diagnosed with Stage I-II ***(Figure 5)***.

Figure 5: Clinical stage at diagnosis for participants with NSCLC



For participants diagnosed with NSCLC, across all stages, a majority had an ECOG score of 0-1. 70% of participants with Stage I-III had an ECOG of 0-1. The proportion of participants with an ECOG 0-1 was lower (53%) in stage IV disease. Participants with Stage IV NSCLC had the highest proportion with ECOG ≥2 (24%) ***(Figure 6)***.

Figure 6: ECOG score for participants with NSCLC by cancer stage



Management and Treatment

Over 85% of participants with Stage I-III NSCLC were presented at a multidisciplinary meeting (MDM). For participants with Stage IV NSCLC, approximately 71% were presented at an MDM ***(Figure 7)***. Only 24% of participants with Stage I-II NSCLC and 38% of Stage IV participants received psychosocial supportive care needs screening. ***(Figure 8)***.

Figure 7: MDM presentation by clinical stage for participants with NSCLC

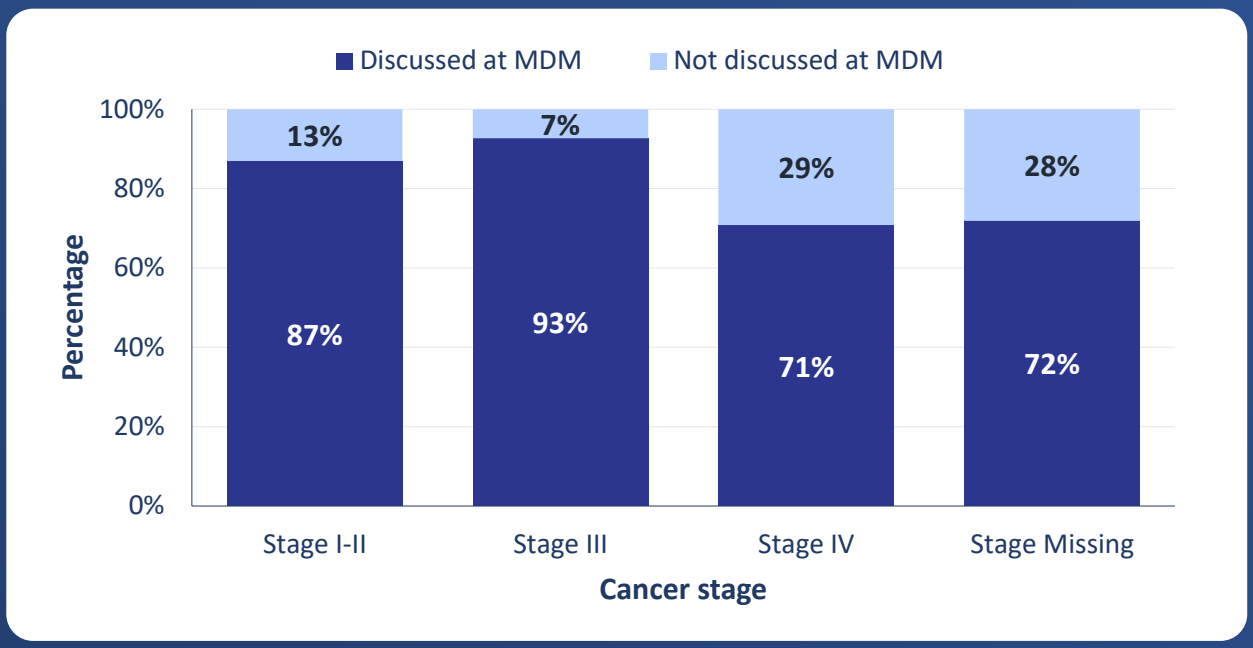
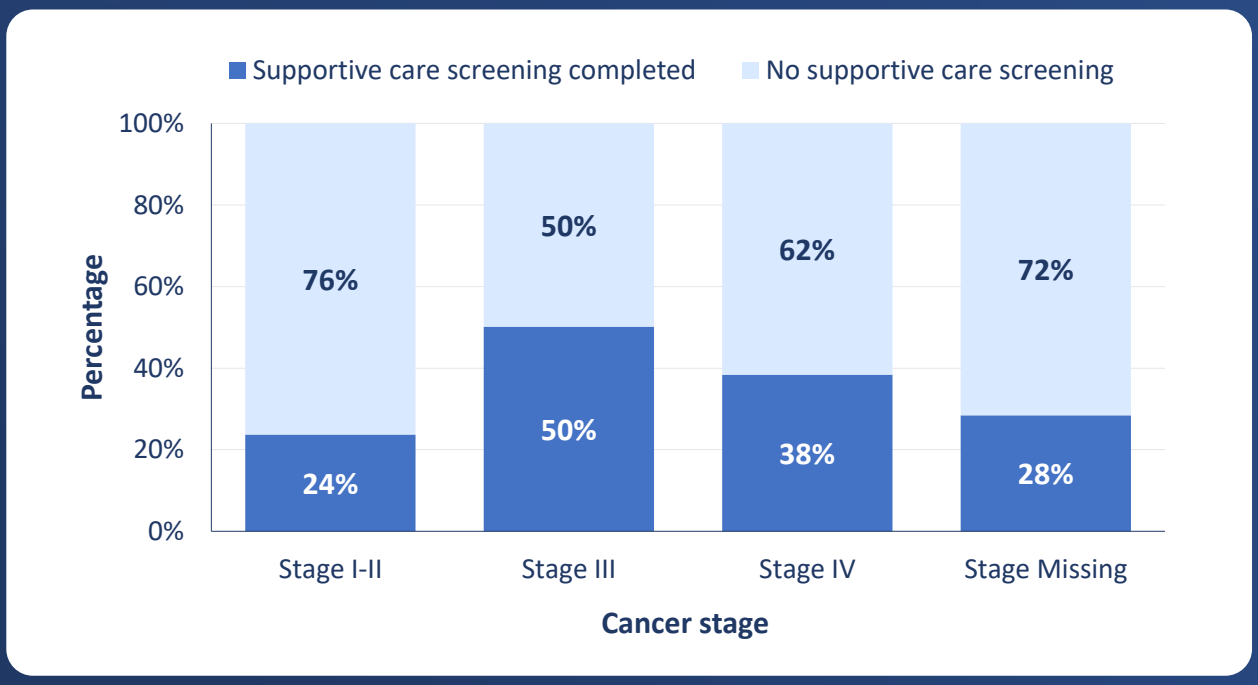


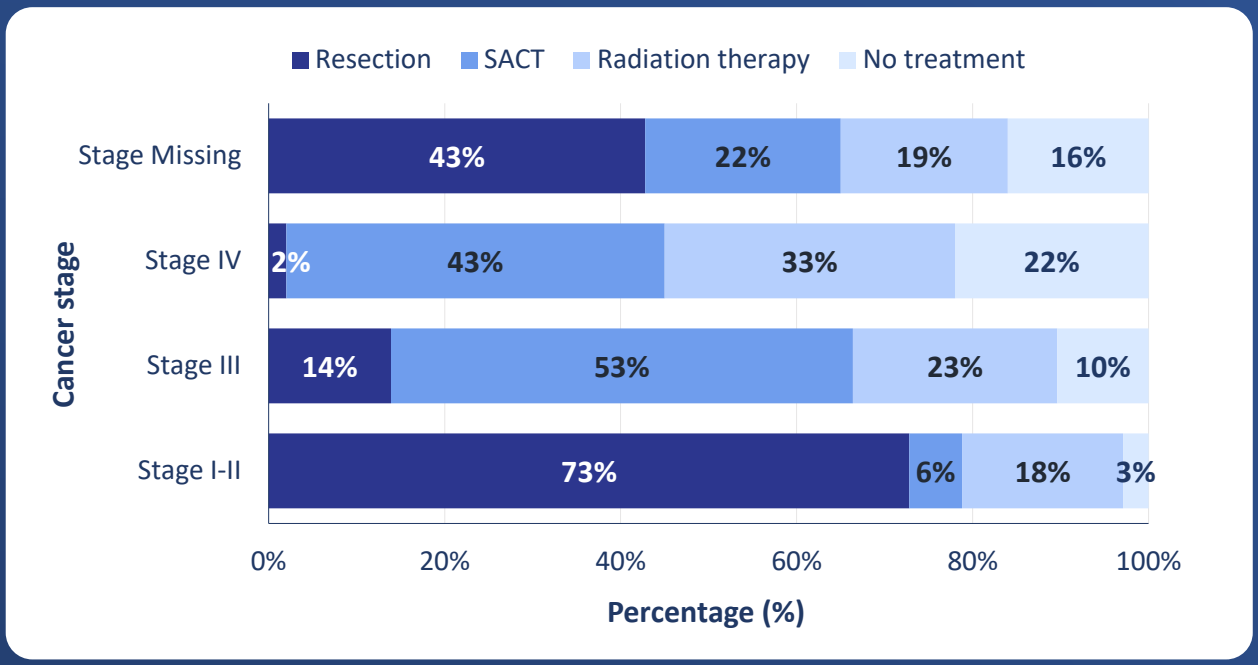
Figure 8: Supportive care screening completed by clinical stage for participants with NSCLC



Treatments Delivered

A large proportion of participants with Stage I-II NSCLC had a surgical resection (73%). For Stage III-IV NSCLC, the highest proportion of participants received systemic anticancer therapy (SACT), followed by radiotherapy. Approximately 22% of participants with Stage IV NSCLC had no treatment, highest amongst all NSCLC stages ***(Figure 9)***.

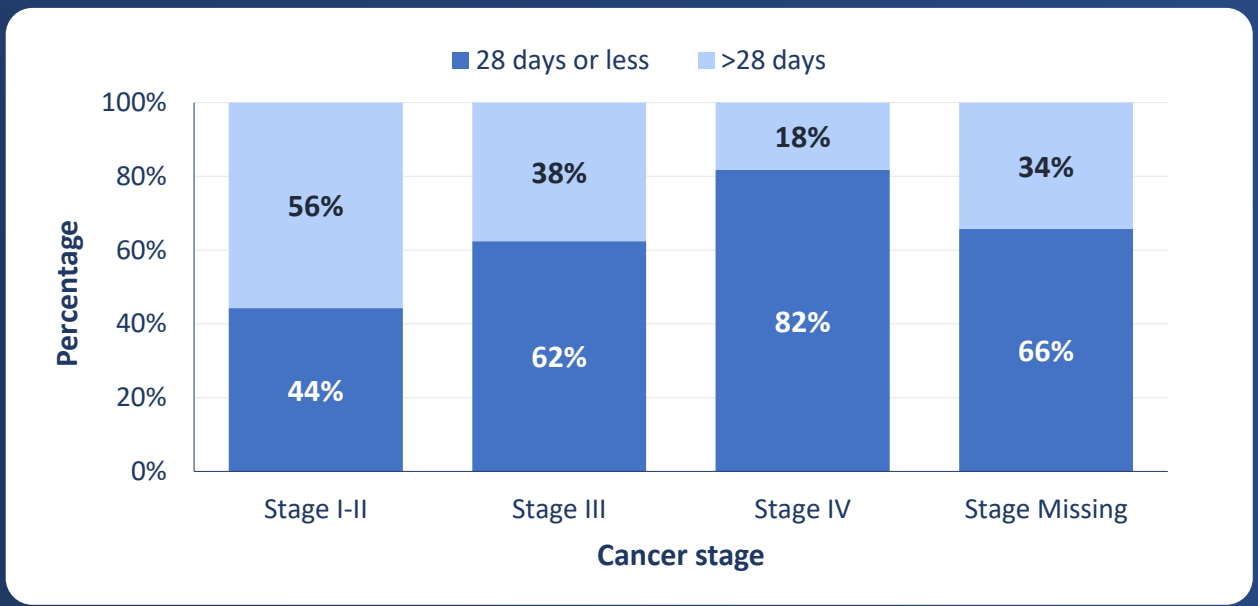
Figure 9: Distribution of first treatment by clinical stage for participants with NSCLC



Timely Treatment

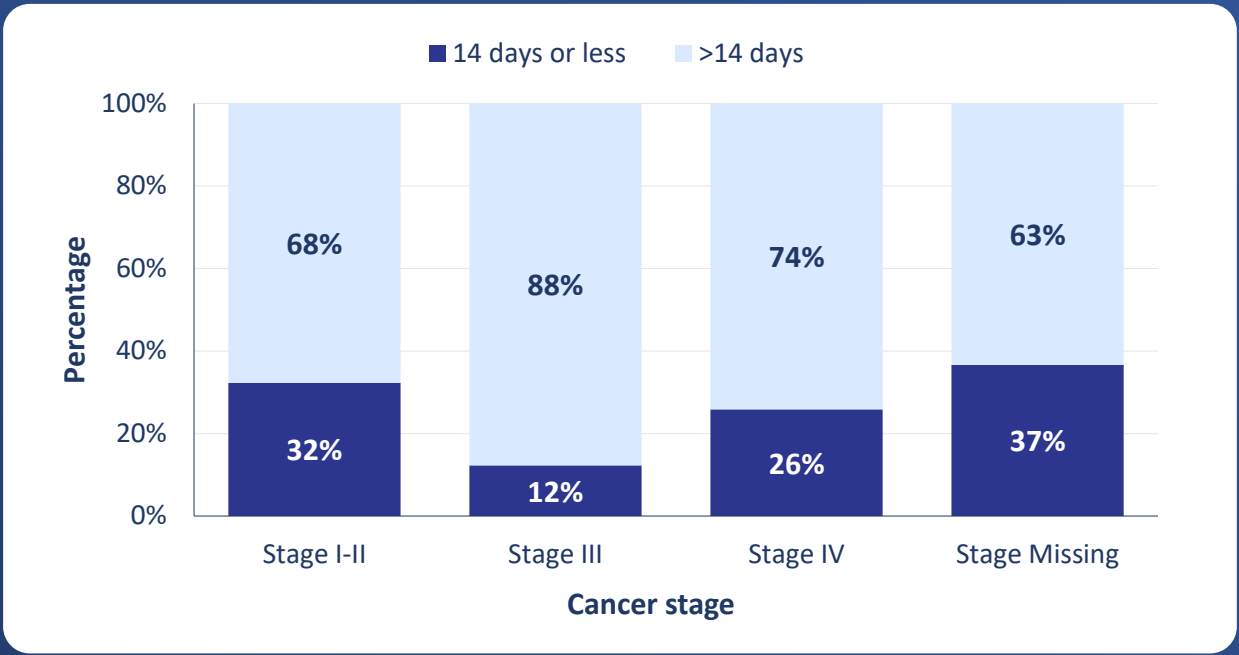
A large proportion of participants with Stage III and IV NSCLC had a referral to diagnosis time of 28 days or less. Only 44% of participants with Stage I-II NSCLC had a diagnosis within 28 days of a referral (***Figure 10***).

Figure 10: Time from referral to diagnosis by clinical stage for participants with NSCLC



A majority of participants with Stage I-II NSCLC (68%) had a diagnosis to treatment time of greater than 14 days. This trend was also seen for participants with Stage III or IV NSCLC. Only 12% of Stage III and 26% of Stage IV NSCLC participants had a diagnosis to treatment within 14 days (***Figure 11***).

Figure 11: Time from diagnosis to first treatment by clinical stage for participants with NSCLC

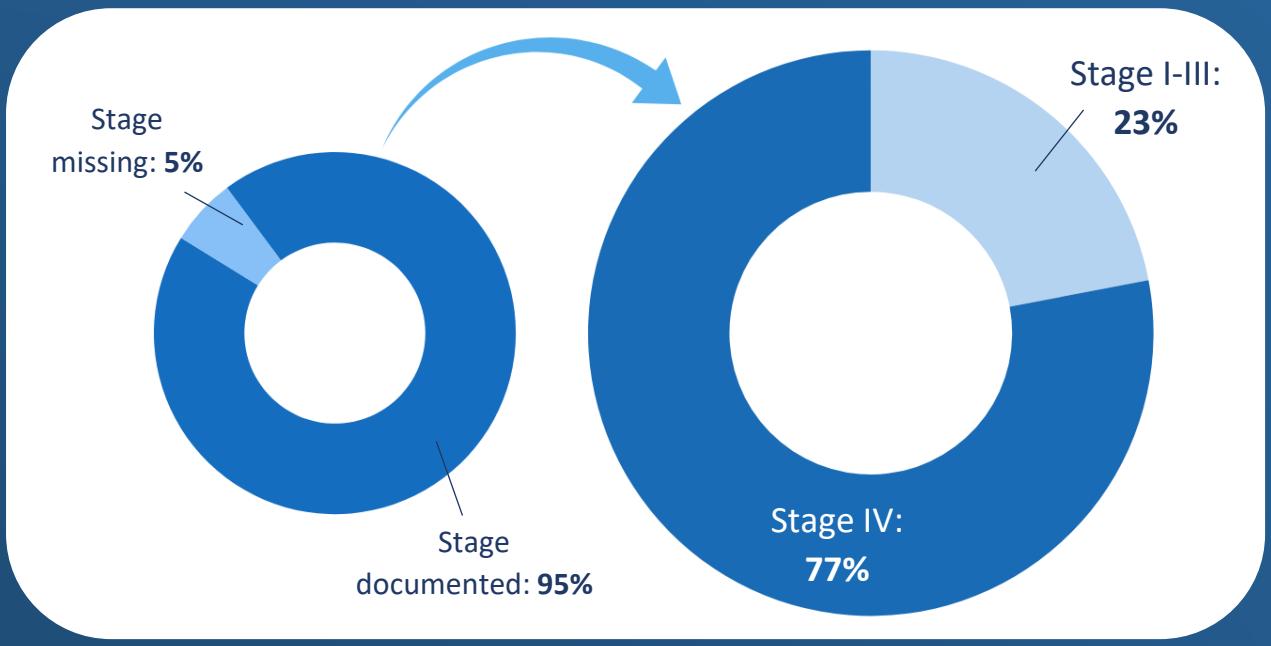


Small cell Lung Cancer (SCLC)

Demographics and Disease

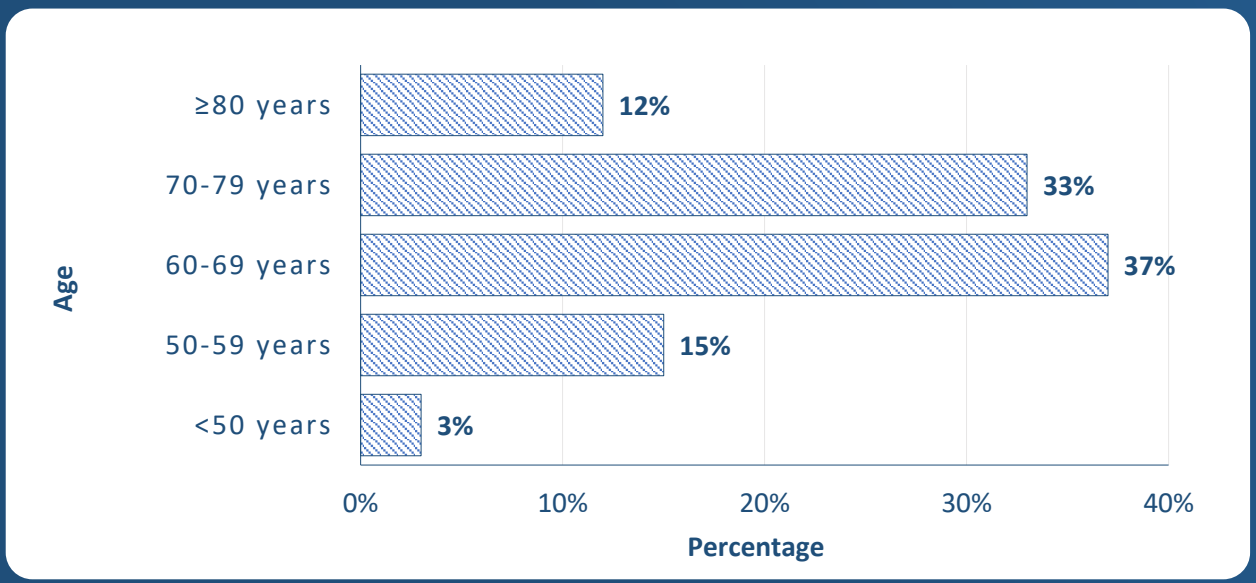
In participants with SCLC who had stage documented, 77% were diagnosed with Stage IV cancer. There was a low proportion of participants that did not have clinical stage documented (5%) ***(Figure 12)***.

Figure 12: Clinical stage at diagnosis for participants with SCLC



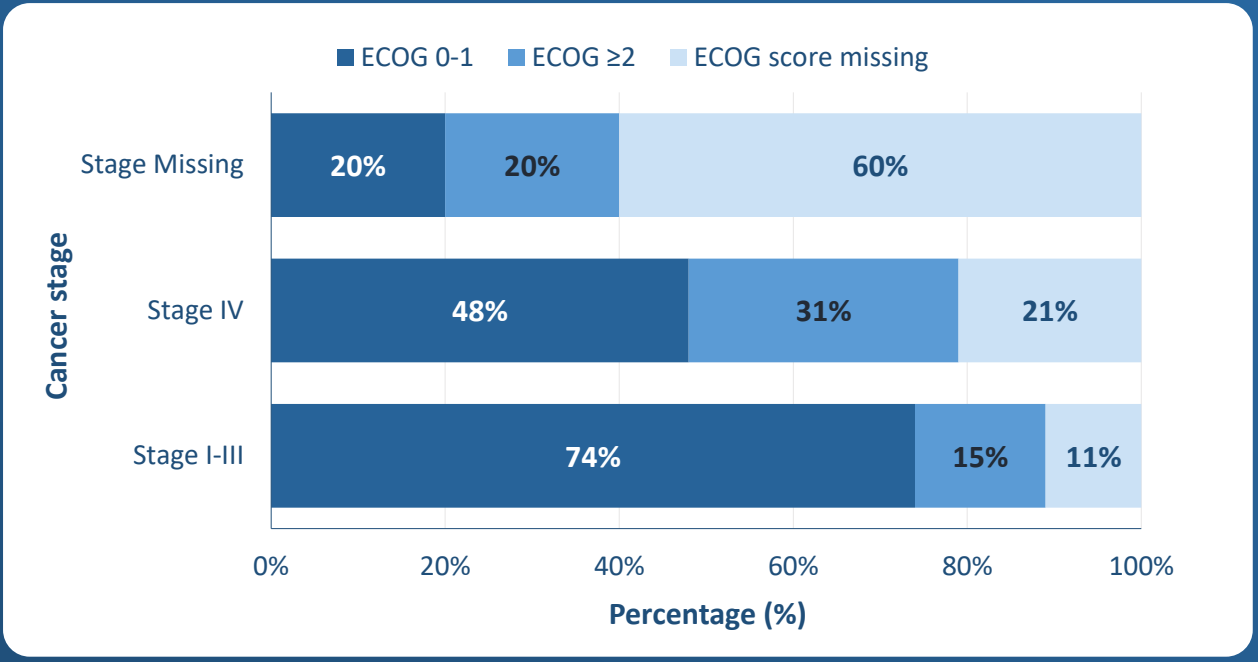
Over 80% of participants with SCLC were 60 years and over with 33% being aged 70-79 years and 12% of participants were aged 80 years and over ***(Figure 13)***.

Figure 13: Age of participants with SCLC



Overall, 56% of participants with SCLC had an ECOG status of 0-1. Participants with Stage IV SCLC had the highest proportion with an ECOG of ≥2 (31%) ***(Figure 14)***.

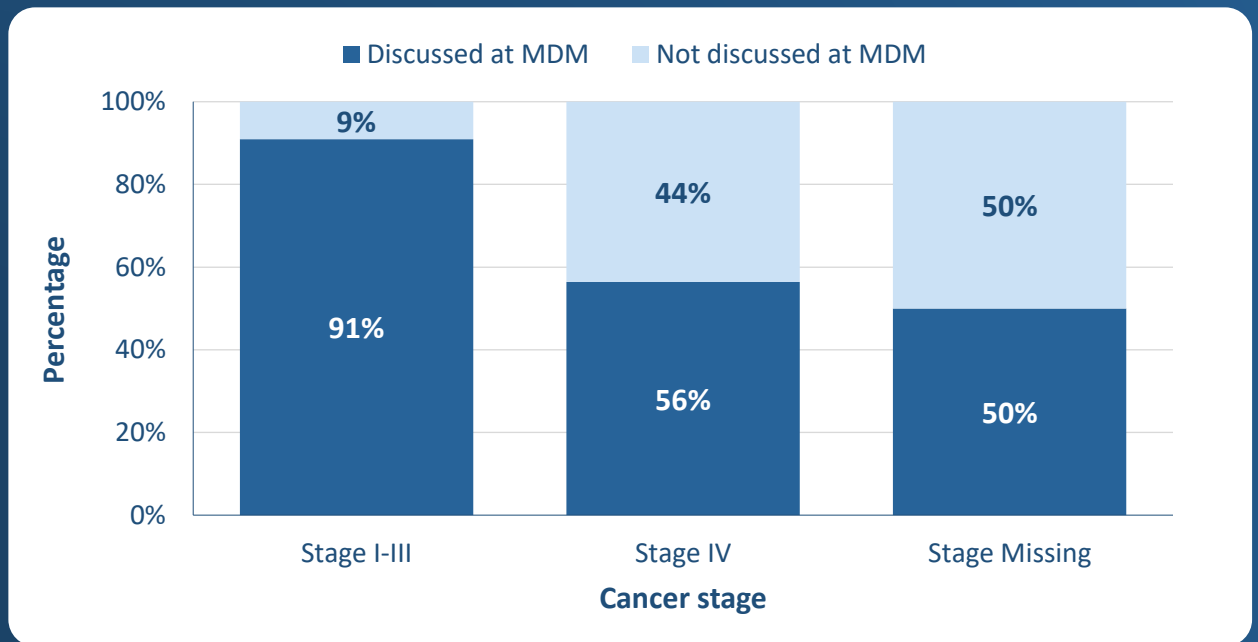
Figure 14: ECOG score for participants with SCLC by cancer stage



Management and Treatment

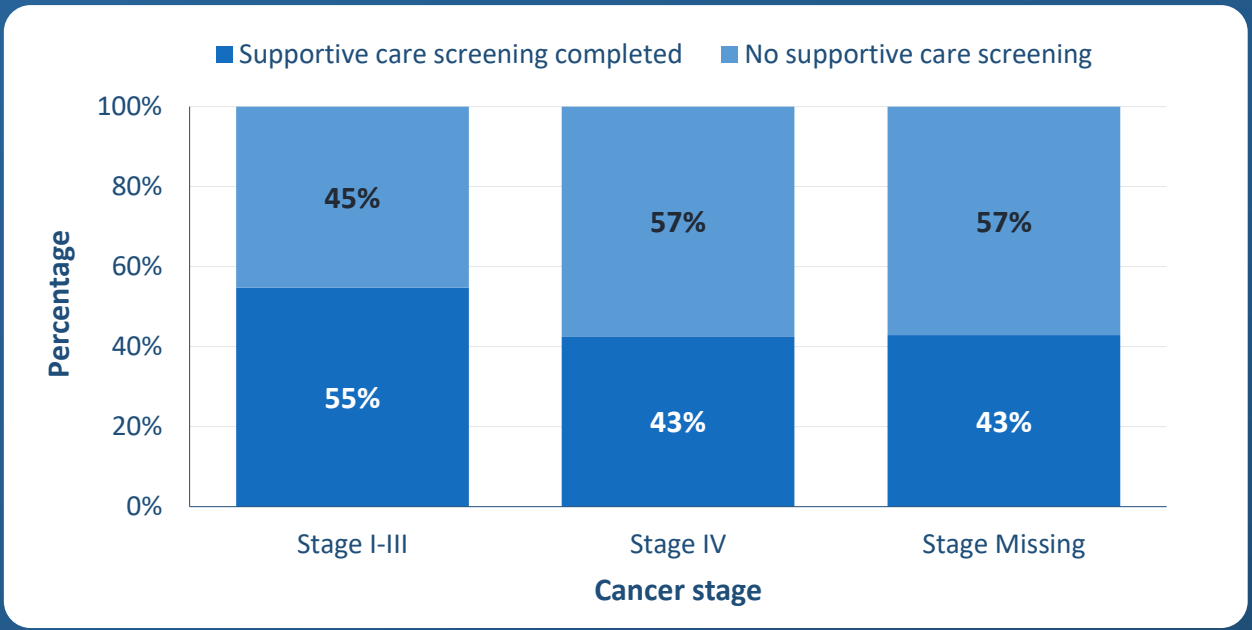
91% of participants with Stage I-III SCLC were presented at an MDM. The proportion of participants presented to an MDM with Stage IV SCLC reduced to 56% ***(Figure 15)***.

Figure 15: MDM presentation by clinical stage for participants with SCLC



Psycho-social supportive care needs screening was undertaken in 55% participants with Stage I-III SCLC. This decreased to 43% for participants with Stage IV SCLC ***(Figure 16)***.

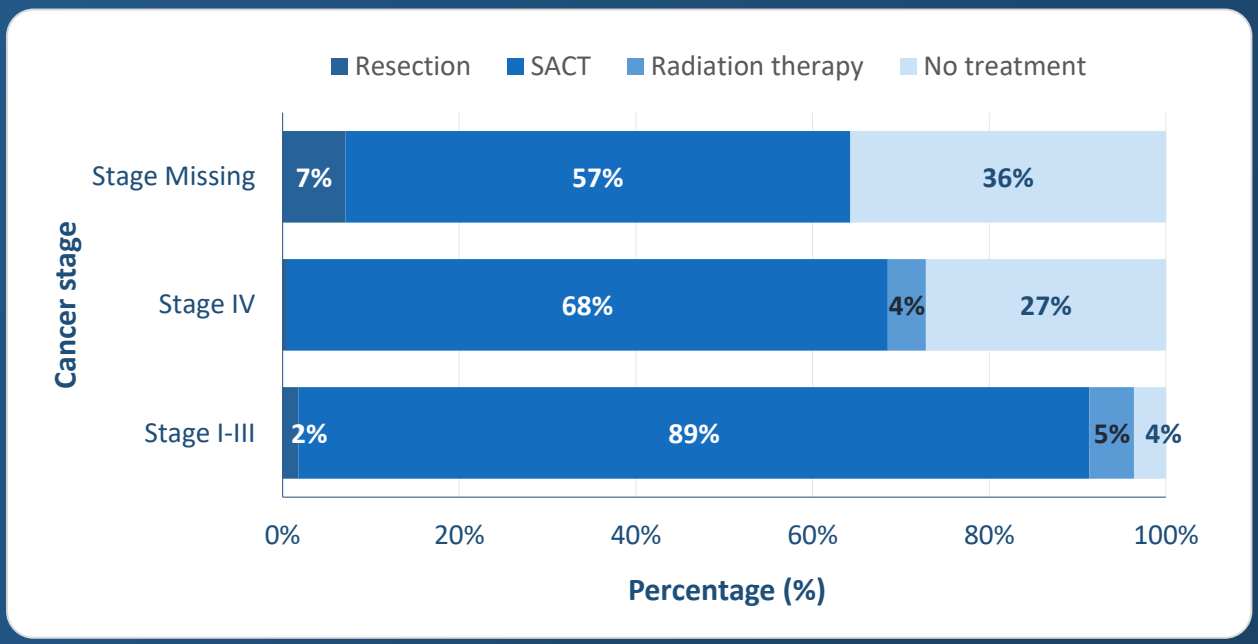
Figure 16: Supportive care screening completed by clinical stage for participants with SCLC



Treatments Delivered

The largest proportion of participants with Stage I-III received SACT (89%). 27% of participants with Stage IV SCLC had no treatment. A high proportion of participants with Stage IV SCLC received SACT (68%) followed by radiotherapy (4%) ***(Figure 17)***.

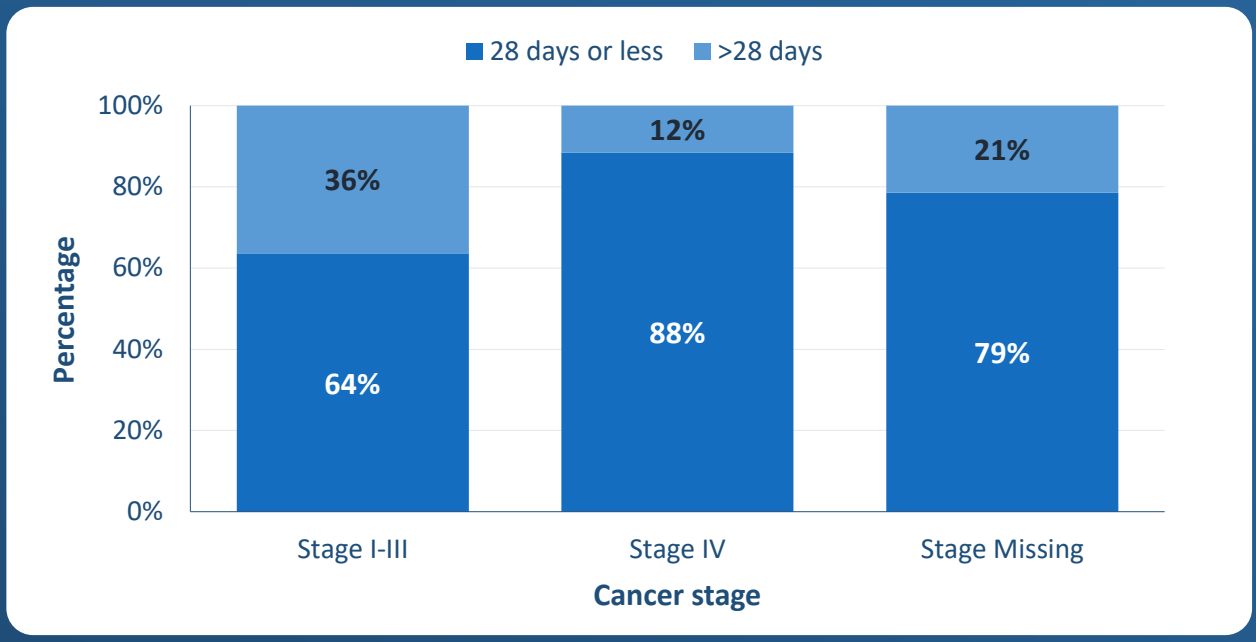
Figure 17: Distribution of first treatment by clinical stage for participants with SCLC



Timely Treatment

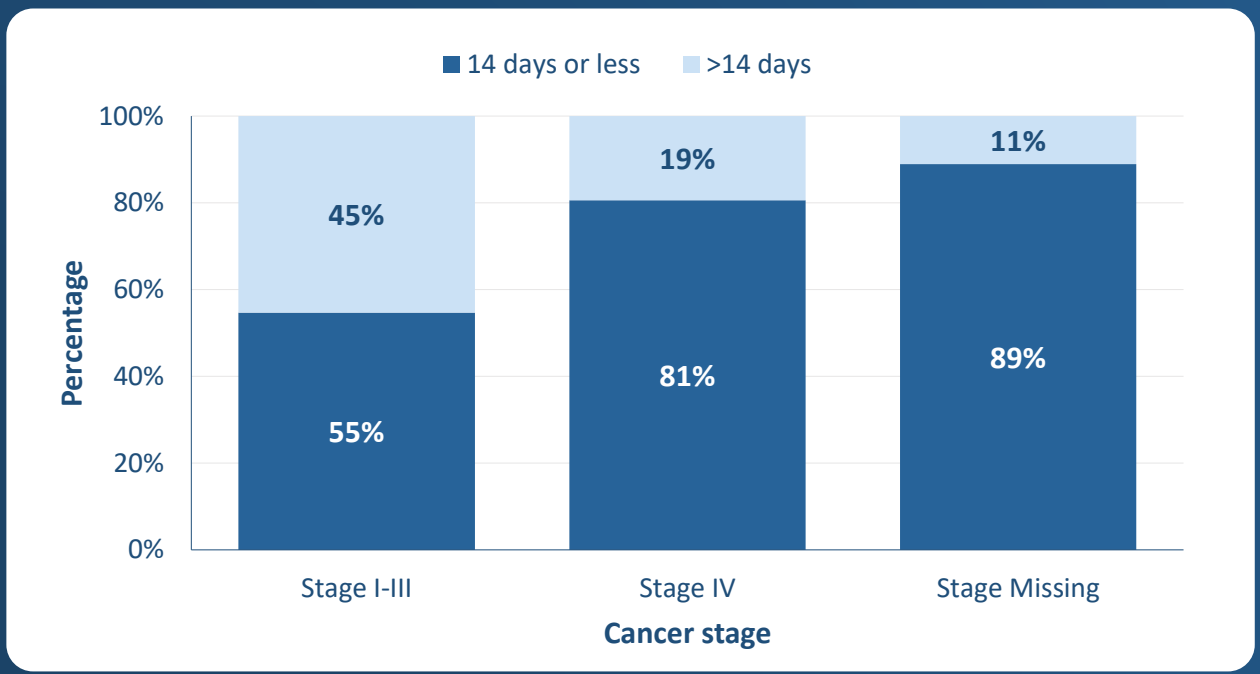
64% of participants with Stage I-III SCLC and a higher proportion of participants with Stage IV SCLC (88%) had a referral to diagnosis within 28 days ***(Figure 18)***.

Figure 18: Time from referral to diagnosis by clinical stage for participants with SCLC



A similar trend was seen for time from diagnosis to treatment with 81% of participants with Stage IV SCLC receiving treatment within 14 days. For participants with Stage I-III SCLC, 55% received treatment within 14 days of diagnosis ***(Figure 19)***.

Figure 19: Time from diagnosis to first treatment by clinical stage for participants with SCLC

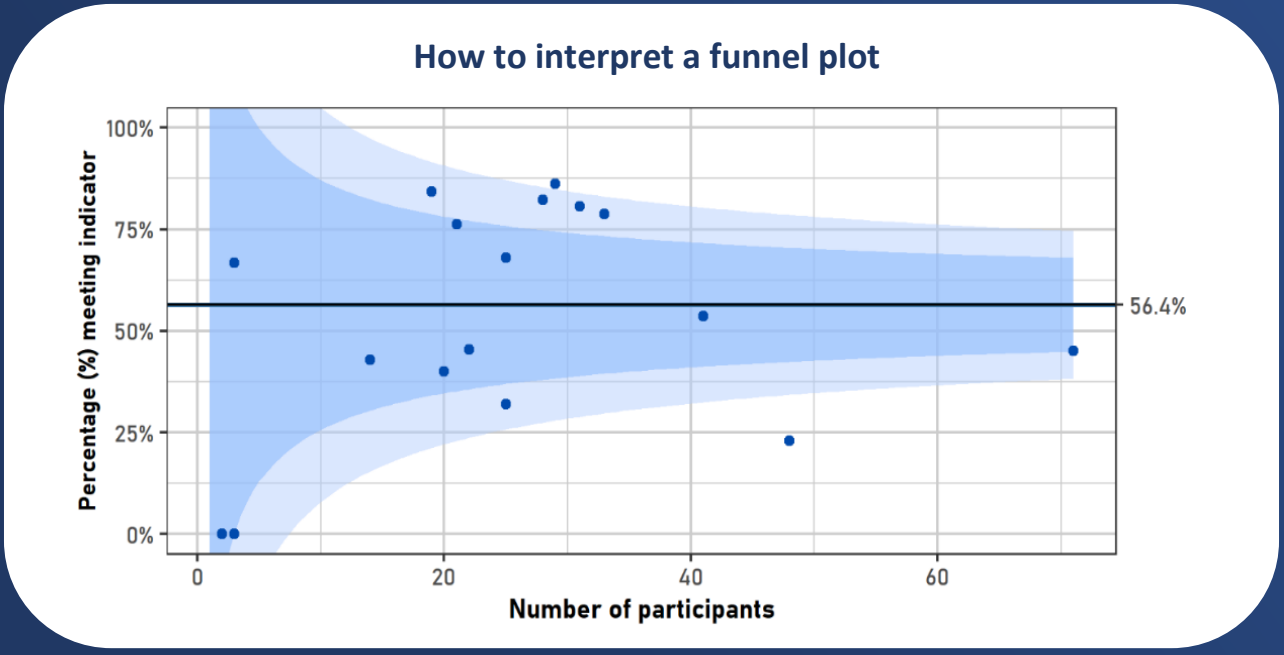


Clinical Quality Indicators

The VLCR collects and reports on data relating to 24 clinical quality indicators (CQIs). The VLCR CQIs have been developed by an expert Delphi working group. They are risk-adjusted and benchmarked against the VLCR cohort. Data for each of the CQIs are presented as funnel plots which are the recommended graphical representation for comparing institutional data.

Each individual site receives an annual CQI report where they can visually compare and benchmark its performance against other VLCR sites. Where a site may be identified as an outlier, processes are in place to validate the data and support the site in reviewing its internal processes. Please refer to the VLCR website for a list of all CQIs with their definitions.

The following quality indicators are grouped to reflect six specific domains of quality of care delivered: **safe, patient-centred, timely, efficient, evidence-based and equitable** [1].



When interpreting funnel plots (see example plot above), the horizontal axis (x-axis) shows the number of participants at each site. The vertical axis (y-axis) measures the performance of each site according to the CQI. Each health service is represented by a dark blue dot.

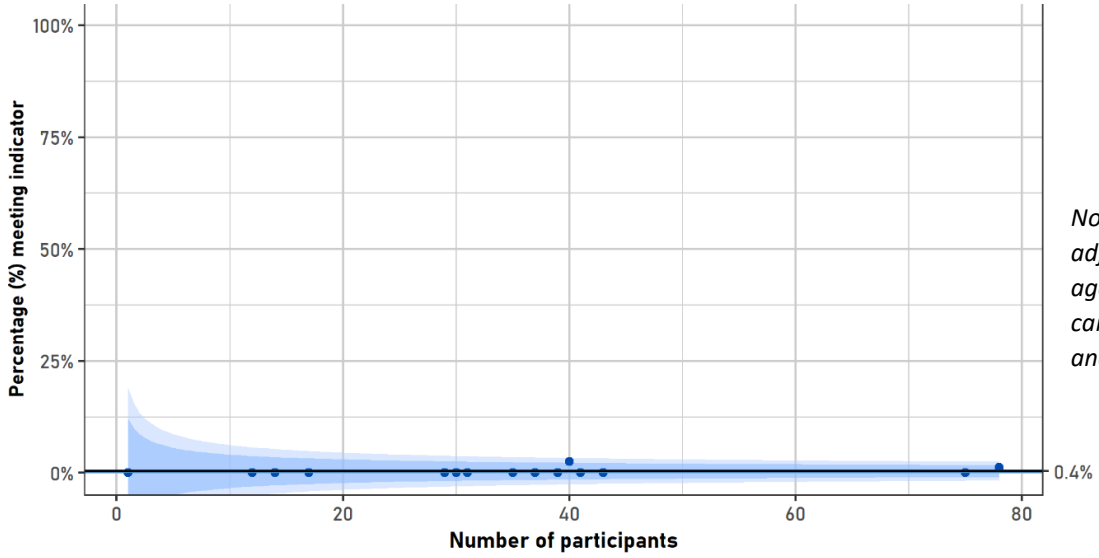
The black line represents the overall mean (percentage meeting the indicator) of observed participants for all health services combined. Sites within the dark blue shaded area indicate their performance is within 95% (two standard deviations) of the overall mean. Sites whose performance is within 99.8% (three standard deviations) of the overall mean are within the light-blue shaded area. Sites outside of the shaded area, fall outside the 99.8% performance.

To the right of the funnel plot, the overall percentage meeting the indicator for 2024.

Safe Health Care

Thirty-day mortality following lung resection is a key safety indicator reflecting perioperative risk and quality of surgical care. The overall mean for proportion of participants with NSCLC who died within 30 days of lung resection was 0.4%, with most health services having their performance within 95% of the overall mean ***(Figure 20)***.

Figure 20: Proportion of participants with NSCLC who died within 30 days of lung resection

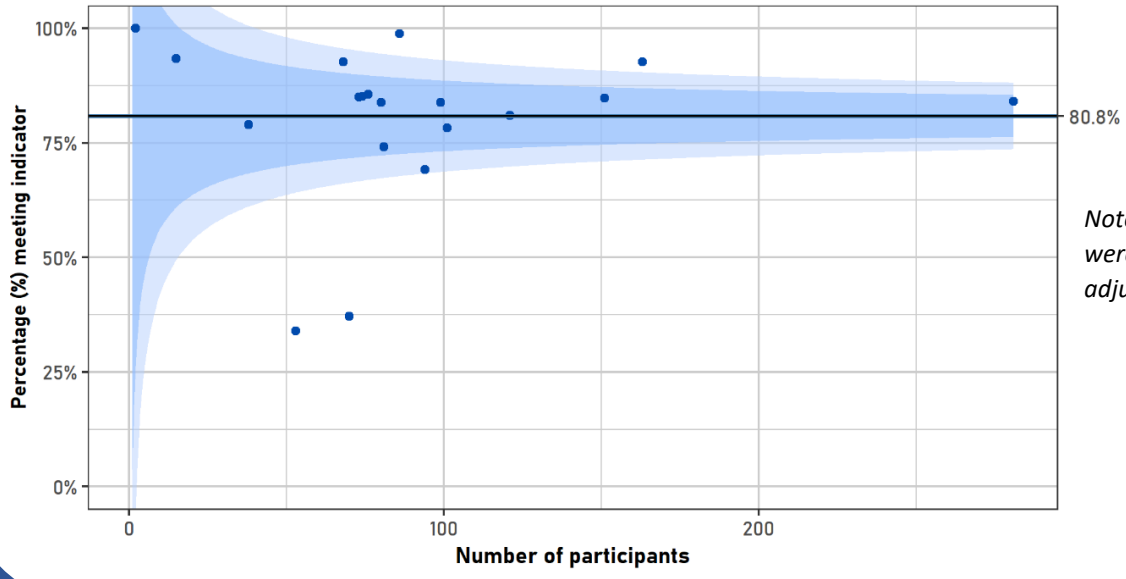


Note: Risk adjusted for age, sex, cancer stage and ECOG.

Effective Health Care

The Australian Lung Cancer Optimal Care Pathway (OCP) recommends that all newly diagnosed lung cancer patients are discussed at an MDM to support coordinated, high-quality care. The overall mean for proportion of participants being presented at an MDM was 80.8%. A majority of the sites were within 99.8% of the mean and two sites were outside this area ***(Figure 21)***.

Figure 21: Proportion of participants presented to a lung MDM

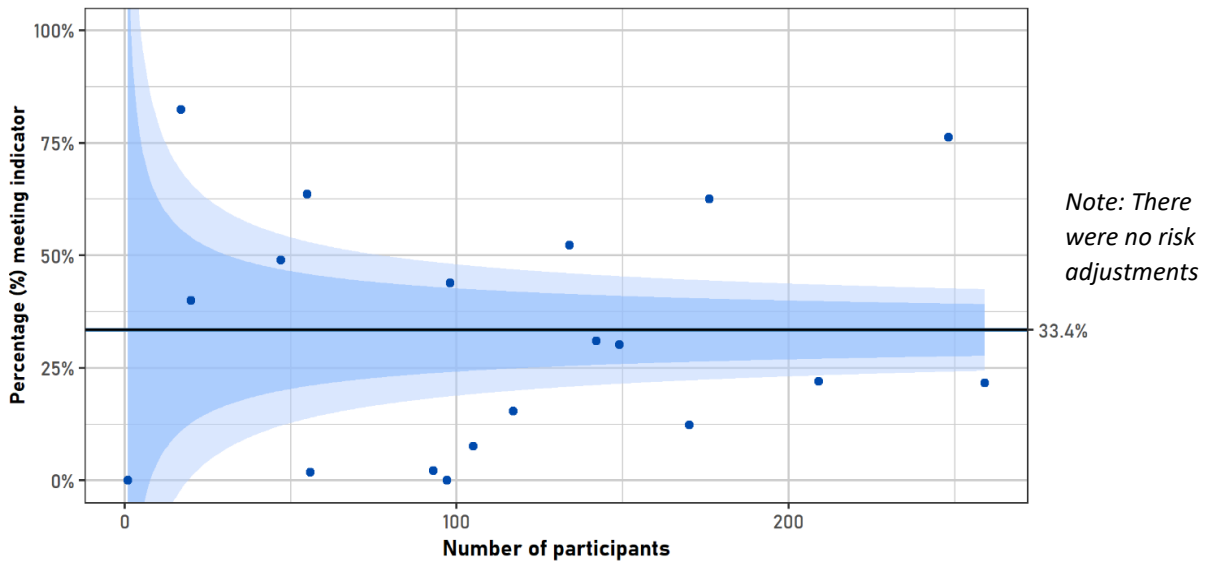


Note: There were no risk adjustments

Patient-Centred Health Care

The Australian Lung Cancer OCP recommends routine screening for psychosocial supportive care needs to support patient-centred care. The overall mean proportion of participants with documented screening for psychosocial supportive care needs was only 33.4% ***(Figure 22)***.

Figure 22: Proportion of participants with documented screening for supportive care

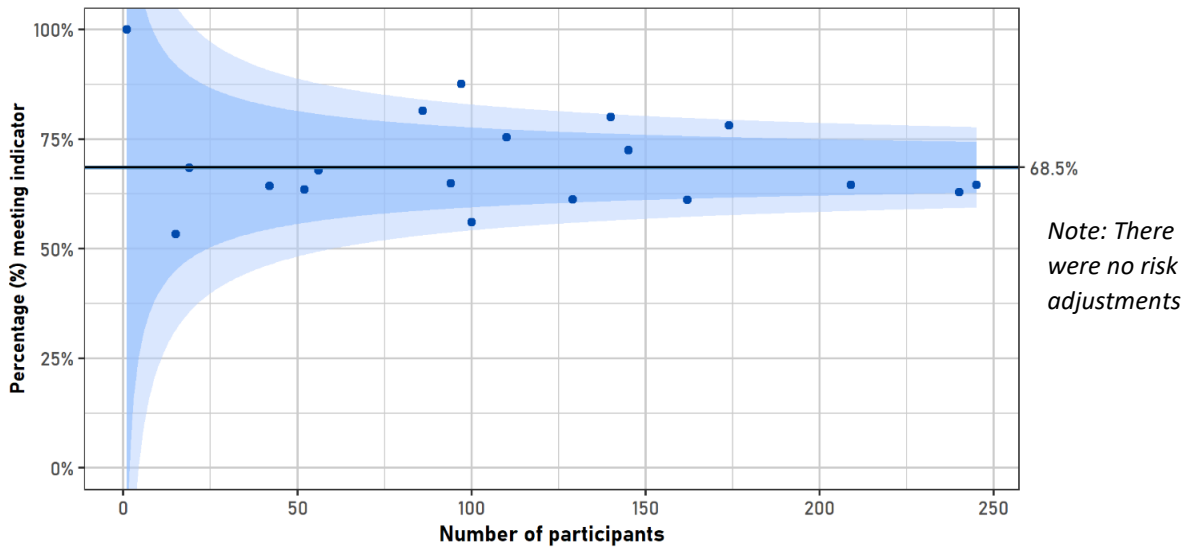


Note: There were no risk adjustments

Timely Health Care

Timely referral to diagnosis and treatment have been identified in the Australian Lung Cancer OCP as key components in patient care. The overall mean proportion of participants where referral to diagnosis date within 28 days was 68.5%. A majority of the health services had their performance within 95% of the overall mean ***(Figure 23)***.

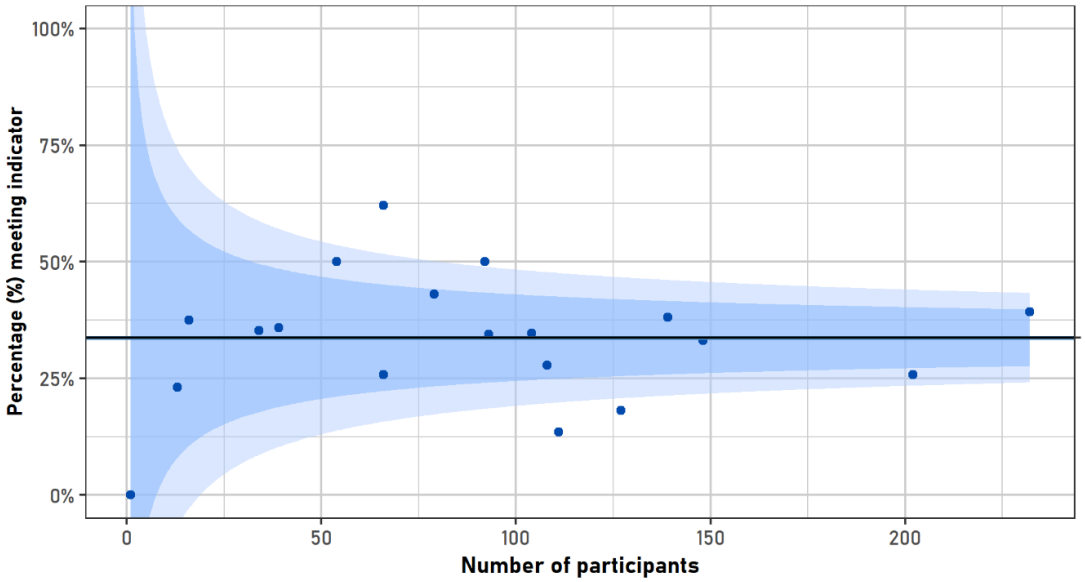
Figure 23: Proportion of participants where referral to diagnosis date within 28 days



Note: There were no risk adjustments

The overall mean proportion of participants where diagnosis to first treatment within 28 days was 33.7%. A majority of the health services had their performance within 95% of the overall mean ***(Figure 24)***.

Figure 24: Proportion of participants where diagnosis to first treatment within 14 days

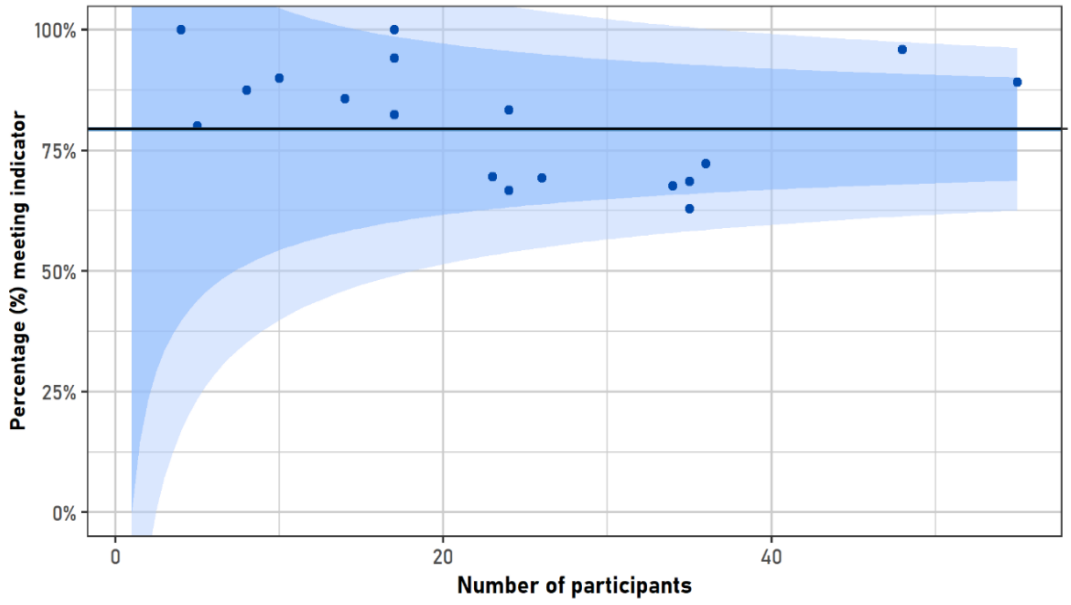


Note: There were no risk adjustments

Efficient Health Care

The overall mean proportion of participants with NSCLC who have an ECOG of 0 to 1 and have commenced systemic anticancer therapy was 79.4% ***(Figure 25)***.

Figure 25: Proportion of participants with NSCLC (clinical stage IIIB, IIIC and IV) who have ECOG (0-1) who have commenced SACT



Note: Risk adjusted for age, sex, cancer stage and ECOG.

Equity in Health Care

Elderly Australians are significantly disadvantaged in relation to access and equity in healthcare. Overall, 72% of patients aged 75 years and over were treated more than 14 days after diagnosis ***(Figure 26)***. 55% of Aboriginal and/or Torres Strait Islander patients received treatment within 14 days of diagnosis ***(Figure 27)***. However, this finding should be interpreted with caution due to the small number of Indigenous patients identified (n = 22) compared to non-Indigenous patients (n=1,741) in 2024.

Figure 26: Proportion of patients aged 75 and over receiving first treatment within 14 days of diagnosis (p<0.001)

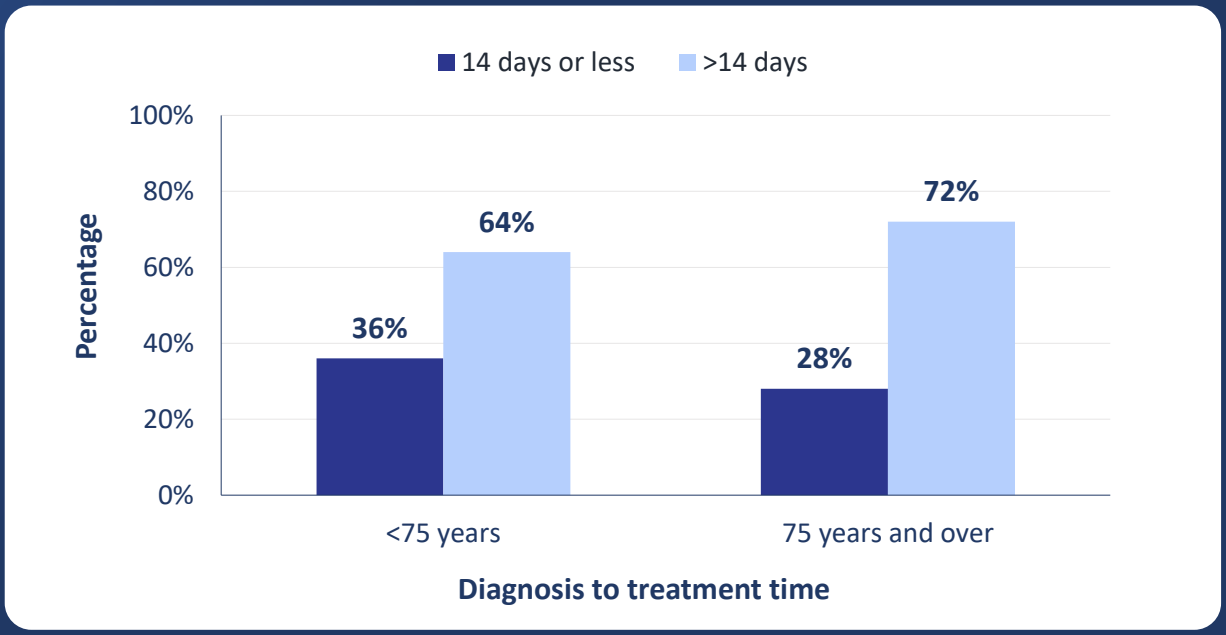
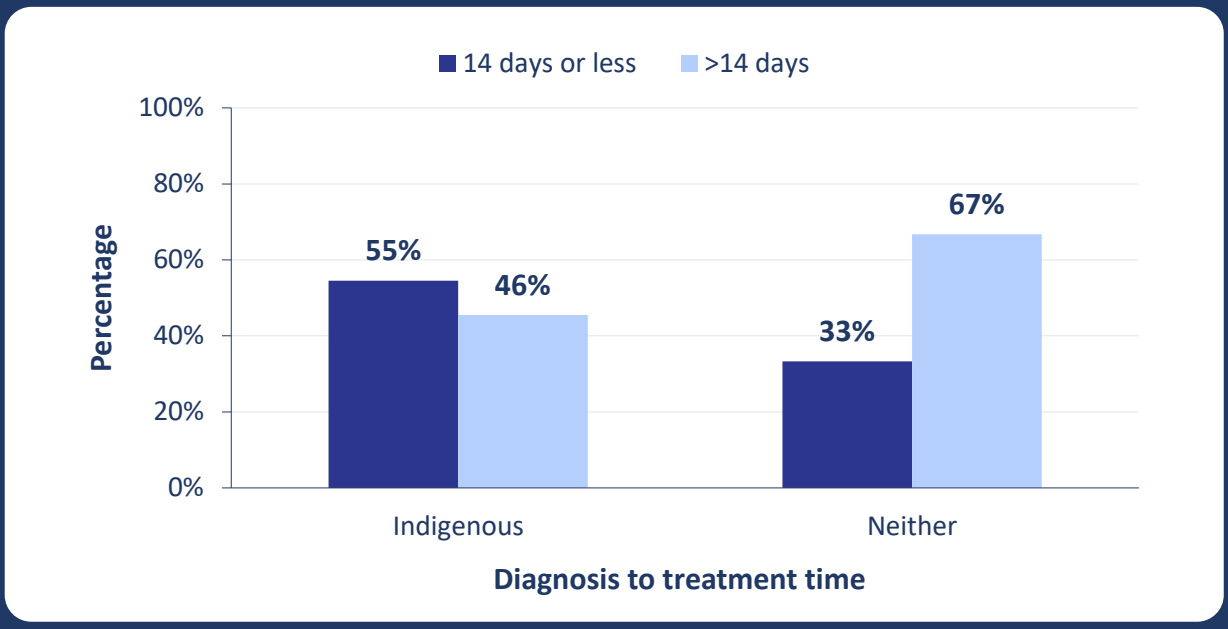
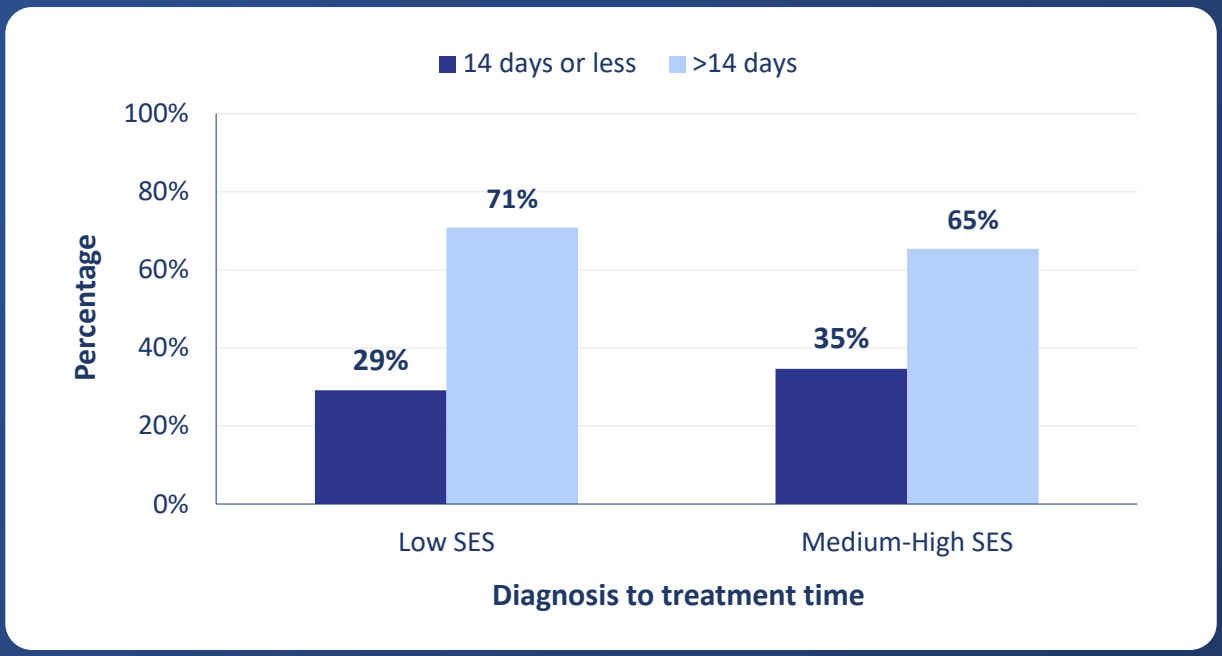


Figure 27: Proportion of Aboriginal and/or Torres Strait Islander patients receiving first treatment within 14 days of diagnosis (p=0.035)



Less than one third of patients with low socioeconomic status were treated within 14 days of diagnosis, compared with a slightly higher proportion of 35% of patients with medium or high socioeconomic status who received treatment within 14 days of diagnosis ***(Figure 28)***.

Figure 28: Proportion of patients with low socioeconomic status* and medium-high socioeconomic status* receiving first treatment within 14 days of diagnosis (p=0.046)



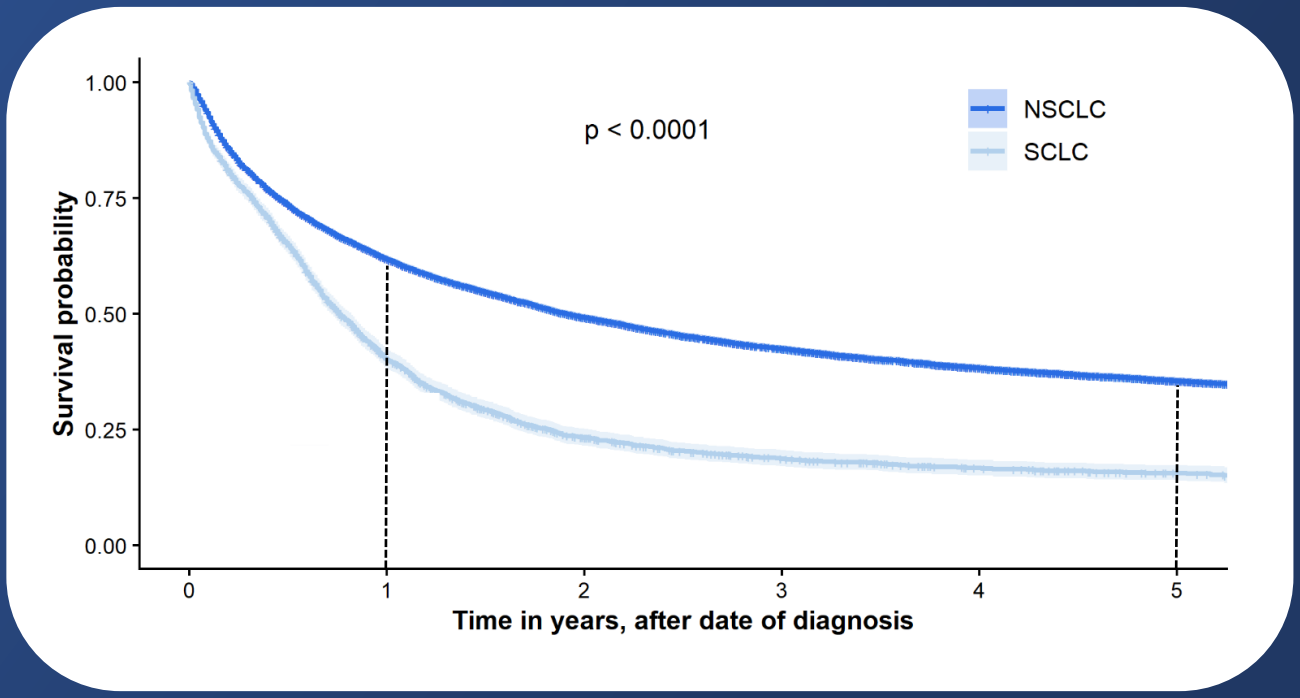
**Socioeconomic status (SES) is defined using the Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) population-based quintiles; low SES = quintile 1, medium-high SES = quintile 2-5.*

Survival of Patients with Lung Cancer

Overall Survival

The 1-year survival rate for participants with NSCLC was 62% and for participants with SCLC was 40%. The 5-year survival for participants with NSCLC was 36% and for participants with SCLC was 16% ***(Figure 29)***.

Figure 29: NSCLC and SCLC overall survival



NSCLC 1-year survival: **62%**

NSCLC 5-year survival: **36%**

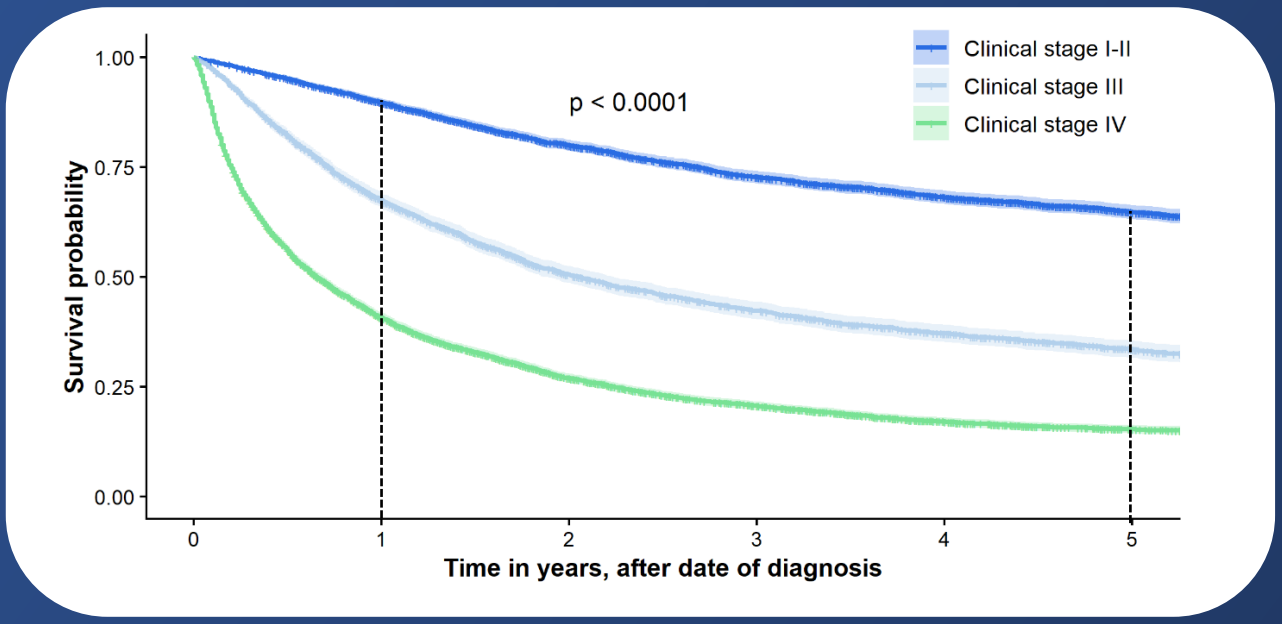
SCLC 1-year survival: **40%**

SCLC 5-year survival: **16%**

Survival by Clinical Stage

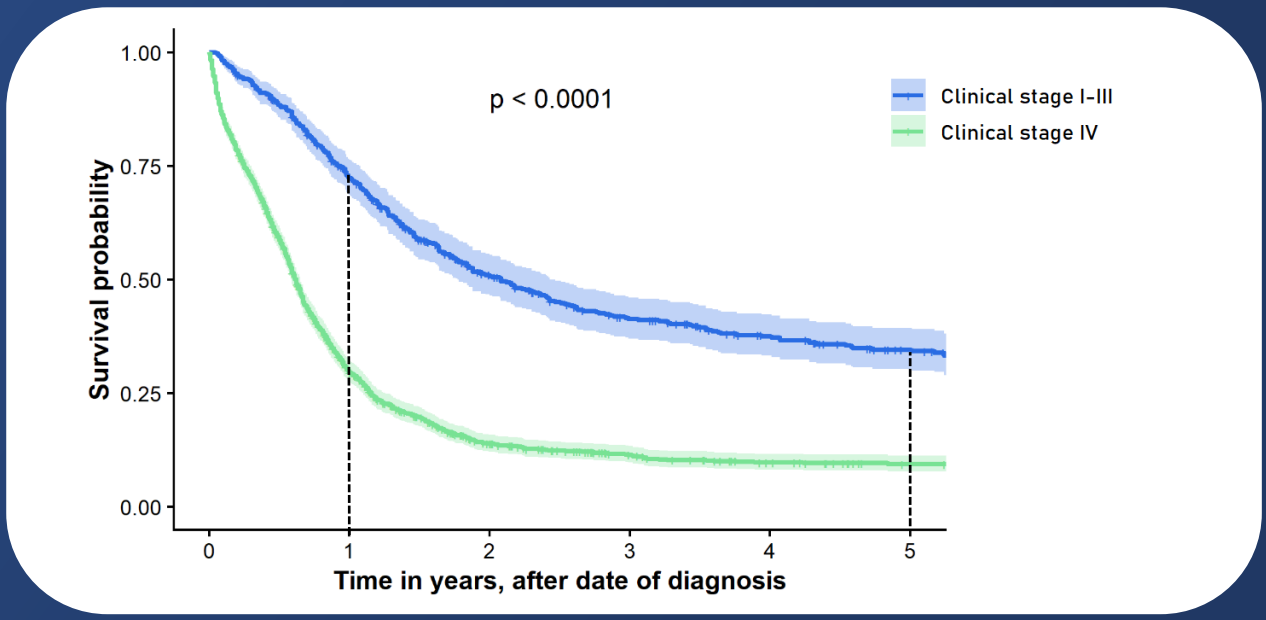
For participants with NSCLC, survival decreased with increasing stage of lung cancer ***(Figure 30)***. A similar trend was seen for participants with SCLC ***(Figure 31)***.

Figure 30: NSCLC survival by clinical stage



	1-year survival		5-year survival
Stage I-II:	**90%**	Stage I-II:	**65%**
Stage III:	**67%**	Stage III:	**34%**
Stage IV	**41%**	Stage IV	**15%**

Figure 31: SCLC survival by clinical stage



	1-year survival		5-year survival
Stage I-III:	**72%**	Stage I-III:	**35%**
Stage IV:	**30%**	Stage IV:	**9%**

Future Opportunities

- Clinical Quality Registry (CQR) reporting supports patients, carers and the wider public by providing insights into the safety, quality, and equity of lung cancer care in Australia.
- With rapidly evolving cancer diagnostics and management, CQR reporting will continue to inform health services and healthcare providers about performance gaps and inequities in care, identifying opportunities to drive evidence-based improvements in service delivery and patient outcomes.
- Patient-centred care is a major policy objective. The deficiency in the completion of psycho-social distress screening represents an improvement opportunity.
- The VLCR will soon introduce routine collection of lung cancer-specific patient reported outcome and experience measures, and incorporate these into regular reporting to stakeholders and the wider community.
- The VLCR's participation in national data linkage initiatives, including the National Health Data Hub led by the Australian Institute of Health and Welfare, will allow the integration of prospective state-level data with national datasets, offering a more complete picture of lung cancer care.
- Strengthened national and state-level governance and stronger partnerships with national agencies will align VLCR activities with national cancer strategies and reporting frameworks. This includes contributing high quality, standardised clinical and outcomes data to support implementation and evaluation of the National Lung Cancer Screening Program.
- Leveraging linked data and advanced analytics, the VLCR will expand registry-based research opportunities and generate real-world evidence to inform clinical practice, service planning and health policy.

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Publications and Presentations

1. Stirling, R. G., Melder, A., Eyles, E., Reich, M., Dawkins, P. An Exploration of the Utility and Impacts of Implementation Science Strategies by Cancer Registries for Healthcare Improvement: A Systematic Review. Int J Health Policy. 2024. Retrieved from https://doi.org/10.34172/ijhpm.8297
2. Tissera S, Billah B, Brand M, Karim MN, Antippa P, Blum R, Caldecott M, Conron M, Faisal W, Harden S, Olesen I, Parente P, Richardson G, Samuel E, See K, Underhill C, Wright G, Zalcberg J, Stirling RG. Stage-Specific Guideline Concordant Treatment Impacts on Survival in Non-small Cell Lung Cancer: A Novel Quality Indicator. Clin Lung Cancer. 2024. doi: https://doi.org/10.1016/j.cllc.2024.08.012
3. Jensen-Marini E, Ayton D, Zalcberg J, Stirling, RG. Exploring patient reported quality of life in lung cancer patients: A qualitative study of patient-reported outcome measures. Asia-Pacific Journal of Clinical Oncology. 2024. doi: https://doi.org/10.1111/ajco.14056
4. Tesema GA, Stirling RG, Tessema ZT, Heritier S, Earnest A. Patient- and Areal-Level Risk Factors Associated With Lung Cancer Mortality in Victoria, Australia: A Bayesian Spatial Survival Analysis. Cancer Med. 2024. https://doi.org/10.1002/cam4.70293.
5. Nash J, Stone E, Vinod S, Leong T, Dawkins P, Stirling RG, Harden S, Bolton A, McWilliams A, O'Byrne K, Wright GM, Brunelli VN, Guan T, Philpot S, Navani N, Brims F; LUCAP investigator team. Lung cancer (internet-based) Delphi (LUCiD): A modified eDelphi consensus process to establish Australasian clinical quality indicators for thoracic cancer. Respirology. 2024. https://doi.org/10.1111/resp.14812.
6. Tissera S, Samuel E, Harden S, Zalcberg J, Stirling RG, Faisal W, Billah B. Timeliness and Guideline-Concordant Treatment in Small-Cell Lung Cancer: Factors Influencing Outcomes in Victoria. 2024. Clinicial Onocology Society of Australasia Annual Scientific Meeting (Gold Coast) [Oral]
7. Harden S, Samankula D,Tissera S, Lloyd M, Hamilton V, Healy B, et al. Prospective Analysis of Patterns of Care and Clinical Outcomes for People Diagnosed with Mesothelioma in Australia. 2024. World Conference on Lung Cancer (San Diego) [Poster]
8. Harden S, Tissera S, Lloyd M, Hamilton V, Healy B, Healy K, et al. Patterns of care, clinical outcomes and patient reported measures for people diagnosed with mesothelioma in Victoria. 2024. COSA (Gold Coast) [Poster]
9. Tissera S, Samuel E, Harden S, Zalcberg J, Stirling RG, Faisal W, Billah B. Timeliness Matters: Factors influencing first specialist appointment and treatment delays in patients with non-small cell lung cancer. 2024. Thoracic Oncology Group of Australasia Annual Scientific Meeting (Sydney) [Poster]
10. Harden S, Samankula D,Tissera S, Lloyd M, Hamilton V, Healy B, et al. Prospective Analysis of Patterns of Care and Clinical Outcomes for People Diagnosed with Mesothelioma in Australia. 2024. World Conference on Lung Cancer (San Diego) [Poster]

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Victorian Lung Cancer Registry

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2024 Annual Report

Victorian Lung Cancer Registry