ANTICOAGULANT TREATMENT

"WE ARE JUGGLING MANY POSSIBILITIES": HEALTHCARE PROFESSIONALS' EXPERIENCES AND PERSPECTIVES ON INTERPRETATION OF PULMONARY EMBOLISM SIGNS AND SYMPTOMS IN PATIENTS WITH LUNG CANCER

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Introduction. Pulmonary embolism (PE) is a frequent and potentially fatal complication in lung cancer. Clinical recognition is challenging because symptoms overlap with cancer- and treatment-related effects, which complicates timely diagnosis.

Aim. To explore healthcare professionals' (HCPs) experiences and perspectives on recognising and interpreting signs and symptoms of PE in lung cancer.

Materials and Methods. Semi-structured interviews were conducted with 14 HCPs involved in assessment and management of lung cancer patients with suspected or confirmed PE across oncology departments and thrombosis centres in Denmark. Interviews were transcribed verbatim and analysed using Framework Analysis following Ritchie and Spencer's five-step approach.

Results. HCPs described PE as presenting with variable and often non-specific respiratory symptoms, typically on a background of pre-existing dyspnoea related to cancer, comorbidity, or treatment. Diagnostic reasoning required concurrent consideration of multiple differential diagnoses, including infection, pleural effusion, pneumonitis, chronic obstructive pulmonary disease, and cancer progression. Acute and marked dyspnoea triggered rapid investigation, whereas gradual or subtle symptom changes were difficult to interpret and were often attributed to established symptom patterns. When PE was suspected, HCPs reported a low threshold for imaging, reflecting awareness of persistent thrombotic risk. Targeted questioning about changes in functional capacity and symptom patterns supported identification of clinically relevant change. However, timely recognition depended largely on patient-initiated contact. HCPs described barriers such as patients' normalisation of gradual deterioration and limited awareness of PE risk. At the same time, concerns about anxiety and information burden constrained how explicitly PE risk was communicated, reducing patients' preparedness to interpret symptom changes as clinically urgent. This created a structural tension between cautious risk communication and the clinical reliance on timely patient-initiated responses.

Conclusions. HCPs describe recognition of PE in lung cancer as clinically demanding, with assessment depending on careful evaluation of symptom change and imaging, as well as on patient-initiated contact, highlighting a tension between limited patient symptom interpretation and cautious risk communication, with implications for timely diagnosis.