

# Mr Lawrence Okiror

**FRCS(CTh) · FRCSEd(CTh)**

Consultant Thoracic &amp; Robotic Surgeon

Guy's and St Thomas' NHS Foundation Trust

London Bridge Hospital · Lister Hospital Chelsea



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Lung Nodule &amp; Robotic Surgery Briefing

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## THE EVIDENCE MOMENT

### Screen-detected lung cancer is now a national reality. The pathway that follows must match it.

Three publications in the last twelve months establish a new clinical landscape for lung nodules and early lung cancer. The challenge is no longer awareness – it is speed, integration, and precision once a nodule is found.

NHS England Lung Cancer Screening Programme – 5-year review (Nature Medicine, March 2026): Over two million people invited. 7,193 lung cancers diagnosed through screening. 63.1% at TNM Stage I. 12.6% at Stage II. National programme rollout to full coverage by 2030.

SUMMIT Study (Lancet Oncology, March 2025): 12,773 high-risk ever-smokers screened across north and central London with low-dose CT. Results confirmed the feasibility of large-scale early detection and directly informed the UK's decision to formalise national screening from April 2025. The majority of detected cancers were amenable to curative surgical treatment.

NLCA State of the Nation 2026 (England, 2024 data): 40% of lung cancers now diagnosed at Stage I–II – up from 32% in 2022. Yet 41% still present at Stage IV, and 30% reach diagnosis via emergency admission. Stage I five-year survival is 80–90%. Stage IV is below 10%.

Screening is working. The bottleneck is now what happens between a positive scan and a curative operation – and how quickly that journey can be completed.

An England-based randomised controlled trial published this year provides the clearest available evidence of where the symptomatic lung cancer pathway currently stands. Across 93,326 GP-requested chest X-rays at five NHS Trusts (LungIMPACT, Woznitza et al., Nature Medicine, 2026), the median time from X-ray to CT was 53 days – against a National Optimal Lung Cancer Pathway standard of 72 hours. AI prioritisation of the worklist made no difference to this outcome; the bottleneck is structural, not technological. For a patient whose CXR has identified a nodule requiring further assessment, 53 days is the documented starting point before any diagnostic workup begins. For patients referred to the private nodule precision pathway, CT review and specialist assessment are available within 2–3 working days.

## Your patient has a nodule. What happens next determines everything.

For nodules  $\leq 10\text{mm}$ , current standard practice is interval surveillance imaging – repeat CT at 3, 6, or 12 months in accordance with BTS guidelines. For the majority of low-risk nodules this is entirely appropriate. What is less often acknowledged is the cost to the patient: months of unresolved uncertainty, with anxiety compounding at each scan cycle. That psychological burden is clinically significant and is increasingly recognised as an underweighted factor in pathway design.

Where diagnostic uncertainty persists or higher-risk features are present, the surveillance interval also carries oncological risk. If a lesion progresses during that period, the stage at which it is ultimately diagnosed may be materially worse. Outcomes for Stage II lung cancer are significantly worse than Stage I – and the difference in prognosis between adjacent stages is not marginal. The same interval designed to avoid over-investigation can, in the wrong case, narrow the curative window irreversibly.

For patients in whom tissue diagnosis is warranted, ION navigational bronchoscopy offers a day-case procedure with a fundamentally different endpoint: diagnostic certainty, not continued surveillance. Intraprocedural fluoroscopy confirms tool-in-lesion positioning in real time for every case, verifying that the instrument has reached the nodule before any biopsy is taken. This is frequently supplemented by cone beam CT for additional three-dimensional anatomical confirmation. Across most ION lists at both GSTT and London Bridge Hospital, rapid onsite evaluation (ROSE) places a cytopathologist in the procedure room to assess tissue adequacy immediately and provide a preliminary diagnosis before the patient leaves the suite – eliminating the delay of awaiting CT-guided percutaneous biopsy results, materially increasing diagnostic yield, and giving the patient an answer the same day.

The following situations warrant a specialist opinion – not as a default, but as a clear clinical option for patients where earlier certainty would change management:

- A solid nodule  $\geq 6\text{mm}$  or part-solid nodule  $\geq 6\text{mm}$  (BTS guideline thresholds)
- Any nodule demonstrating growth on serial imaging
- A screen-detected nodule requiring specialist MDT evaluation and tissue diagnosis
- A known or suspected early lung cancer where lung-sparing resection is being considered
- A patient requiring second opinion on surveillance vs. intervention

No GP referral letter is required for private assessment. Patients can contact the service directly or be introduced by you. Appointment within 2–3 working days.

## One consultant. One pathway. Assessment to surgery.

Every element of the diagnostic and surgical journey is managed by the same specialist – with direct access to the UK's highest-volume ION bronchoscopy programme and a fully robotic lung resection practice.

1

### 1. CLINICAL ASSESSMENT

Initial consultation within 2–3 working days at London Bridge Hospital, Lister Hospital Chelsea, or outreach clinics at Canary Wharf and City of London. Full CT/PET review, risk stratification, and management plan at first appointment. No GP referral required.

2

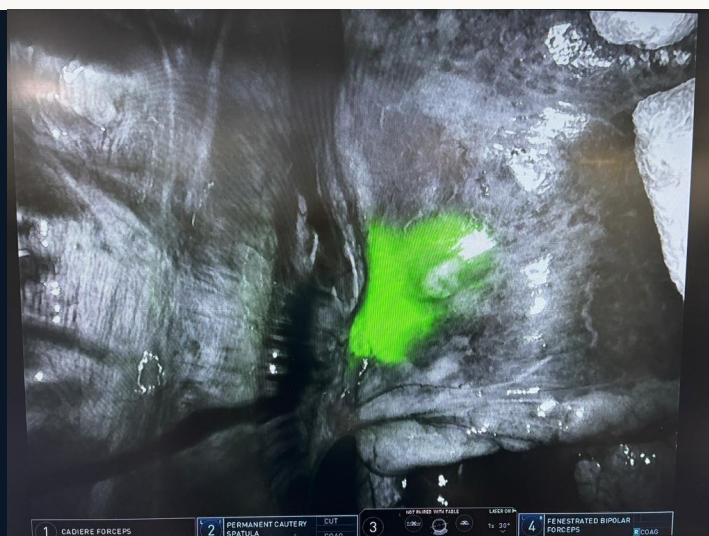
### 2. ION NAVIGATIONAL BRONCHOSCOPY WITH DYE-MARKING

Where tissue diagnosis is warranted, ION robotic bronchoscopy is performed at GSTT or London Bridge Hospital. GSTT has carried out over 900 ION procedures in the last 12 months, making it the highest-volume ION centre in the UK. Intraprocedural fluoroscopy confirms tool-in-lesion positioning in real time for every case, frequently supplemented by cone beam CT. Across most ION lists at both sites, rapid onsite evaluation (ROSE) places a cytopathologist in the room to assess tissue adequacy immediately – giving the patient a preliminary diagnosis before leaving the suite. Indocyanine green (ICG) fluorescent dye is injected at the nodule at the same session, creating a permanent intraoperative marker for subsequent resection.

3

### 3. ROBOTIC RESECTION WITH INFRARED NODULE LOCALISATION

At the time of robotic surgery, the da Vinci FireFly infrared camera illuminates the ICG dye in real time, generating a precise fluorescent signal to guide nodule localisation. This is critical for small or deep nodules that cannot be reliably localised by palpation alone – common in screen-detected, sub-centimetre lesions. Lung-sparing segmentectomy is performed wherever oncologically appropriate, preserving lung function without compromising margins.



#### INTRAOPERATIVE IMAGING – DA VINCI FIREFLY INFRARED CAMERA

ICG fluorescent dye (green) injected at ION navigational bronchoscopy marks the nodule for resection. The da Vinci's FireFly infrared camera activates the signal intraoperatively, providing real-time localisation for small or deep lesions that cannot be reliably identified by palpation.

## Operative volume and quality benchmarks

The service operates within one of the highest-volume thoracic surgical units in the UK, with outcomes confirmed by the Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS).

# 153

Personal anatomic lung resections in 2024–25

SCTS confirmed

# 80%+

Of resections performed robotically or by VATS

Minimally invasive approach

# 900+

ION procedures at GSTT in the last 12 months

Highest-volume ION centre in the UK

# 99.16%

Operative survival (GSTT departmental, 2023–24)

vs 98.5% national benchmark (SCTS)

*GSTT departmental data (2023–24): 837 anatomic resections; 57.8% robotic vs 24% national average; 6% wedge resection rate vs 14% national. 99.16% operative survival vs 98.5% national benchmark (SCTS).*

Institutional context: Guy's and St Thomas' NHS Foundation Trust holds the #1 and #2 positions in the UK in the Newsweek World's Best Hospitals 2026 ranking, independently assessed across 32 countries. London Bridge Hospital, where Mr Okiror conducts his private thoracic practice, is ranked #10 — the highest-ranked private hospital in the country. [rankings.newsweek.com/worlds-best-hospitals-2026/united-kingdom](https://rankings.newsweek.com/worlds-best-hospitals-2026/united-kingdom)

## REFERRAL

### How to refer your patient

Private patients can be seen within 2–3 working days at London Bridge Hospital, Lister Hospital Chelsea, Canary Wharf, or City of London outreach clinics. Insurance authorisation codes are confirmed on first contact. No GP referral letter is required, though a brief summary of imaging findings is helpful.

PA	Grace Jones
EMAIL	pa@lungsurgeon.co.uk
TELEPHONE	020 7952 2882
INSURERS	AXA · BUPA · WPA · Vitality · Cigna · Aviva · and other major insurers · Self-pay
ACCESS	No GP referral required · Appointment within 2–3 working days

LUNG NODULE PRECISION PATHWAY

ROBOTIC SURGERY SERVICE

SCREENING & EARLY DETECTION

Mr Lawrence Okiror · FRCS(CTh) · FRCSEd(CTh)

Consultant Thoracic & Robotic Surgeon · Guy's and St Thomas' NHS Foundation Trust  
Private Practice: London Bridge Hospital · Lister Hospital Chelsea · Canary Wharf · City of London

lungsurgeon.co.uk · pa@lungsurgeon.co.uk · 020 7952 2882

Clarity before intervention.