Reply to: Improving Lung Cancer Screening Uptake

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To the editor,

We read Wilson’s response letter to both our Lung Screen Uptake trial (LSUT, 1) and accompanying editorial by Burnett-Hartman and Wiener (2), with great interest and value the insightful discussion they raise. Together we share in the challenge of achieving both equitable and informed uptake of LDCT lung cancer screening by high-risk individuals, but the differences between the UK and US that Wilson raises are important for how we intervene. The UK benefits from a coordinated and universal primary care system and we appreciate that sending postal invitations directly from the individual’s PCP is a strategy that may not translate directly to the US context. We also note the requirement by the Centers for Medicare and Medicaid for a separate shared decision-making session prior to the screening intervention in the US. However, evidence suggests that the behavioural components of LSUT’s strategy (healthcare professional endorsement and proactively inviting and arranging appointments) are the ‘active ingredients’ which could be implemented in different ways in the US context.

We also share Wilson’s interest in broadening LSUT’s ‘Lung Health Check’ approach to screening to include other aspects of lung and heart health in the future. Framing lung cancer screening as one optional test within a ‘Lung Health Check’ was intended to improve engagement by minimising fear (that could lead to information avoidance and uninformed non-participation) and to provide an in-person supportive environment where shared decision-making about the screening offer could be achieved. Through this we found potential for other lung and heart health interventions – the key focus of Wilson’s point. This includes parallels with the Pittsburgh Lung Cancer Screening Study (PLuSS, 3) which found prevalence of emphysema and airway obstruction increased with individual lung
cancer risk. For example, work led by Ruparel found a significant proportion of undiagnosed COPD (4) and untreated coronary artery calcification (5) within our LSUT cohort, suggesting opportunities for early diagnosis of COPD, instigating cardiovascular risk assessment and primary prevention. The UK taxpayer’s universal healthcare system may in the future fund LDCT screening scans and so we would not have the financial disincentives as the US in this respect. However, the UK does have limited resource for subsequent health care provision for incidental findings. This makes the feasibility of delivering a holistic health assessment challenging and policy decision-makers would (rightly) first require evidence for the public health benefit and cost-effectiveness of such an approach.
References


