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LUNG CANCER ALLIANCE POSITION PAPER ON EARLY DETECTION

As an organization whose mission is to advocate for those with and at risk for lung cancer, it is our responsibility and our obligation to take a position on the issue of lung cancer screening, to exert pressure on the public health policy establishment and to draw the public into this debate from which they have been effectively excluded.

For the past several years, Lung Cancer Alliance (LCA) has been monitoring the scientific debate over the use of low-dose CT (LDCT) for lung cancer screening. The debates over mammography and PSA (prostate specific antigen) screening have been informative. In reviewing their histories, it is evident that both were pushed to “resolution” by strong political pressure despite the objections of many in the public health community. To this date, some experts, citing various studies and randomized controlled trials, remain insistent that mammograms for women under fifty have no impact on mortality and indeed could contribute to mortality in that age group. Others still maintain that mammograms and PSA tests give too many false positive results that lead to unnecessary and potentially harmful treatments and anxiety.

Moreover, the U.S. Preventive Services Task Force (which rates screening tests) has given PSA testing an “I” recommendation (insufficient evidence to recommend for or against). Lung cancer screening also has an “I” rating. While this rating is used to oppose CT screening for lung cancer, the same “I” rating is not brought up to question the efficacy of PSA testing. These inconsistencies remain unchallenged in the scientific community and the public arena.

Meanwhile lung cancer continues to cause nearly one in three cancer deaths and, with the baby boomers now entering their sixties, the number of deaths will continue to escalate. According to National Cancer Institute SEER figures, only 16% of lung cancer is being diagnosed at an early, localized stage when treatment can be effective. It is no surprise, then, that the 5 year survival rate for lung cancer is still only 15%, while cancers such as breast and prostate, with accepted (albeit still controversial) screening tests have 5 year survival rates of 85% and 99% respectively.

Meanwhile, for the past 13 years, the International Early Lung Cancer Action Program (I-ELCAP) has accrued over 50,000 CT scans from 30,000 high risk people (smokers or former smokers over age 50, with a greater than 10 pack year history of smoking) in observational trials carried out in 40 sites in the U.S. and around the world. Because of their work in analyzing suspicious nodules and the protocol they developed for the management of early disease, the I-ELCAP program has produced 10 year survival rates of 85%.

Critics of the I-ELCAP program contend that those figures are “meaningless” since the study did not include a control arm of people who were not given CT scans. They further contend that no additional work should be done on CT screening until completion of the National Lung Cancer Screening Trial (NLST) funded by the National Cancer Institute and the American Cancer Society.

NO MORE EXCUSES. NO MORE LUNG CANCER.

LCA contends the “control arm” for the I-ELCAP trial was the unscreened population and that the NLST itself is a very poorly designed trial. The NLST, started in 2002, compares outdated chest x-rays to outdated single and four slice CT scanners that have since been replaced by far more sensitive sixteen, thirty-two and sixty-four slice scanners. It is unconscionable for any agency, public or private, to block lung cancer screening for high risk populations on the basis of a flawed study which will not be completed until 2009 or beyond. During that time, another one million people will die of lung cancer.

LCA POSITION

In order to ensure the most rapid and responsible dissemination of this potential benefit, screening for lung cancer in high risk populations, LCA recommends that the following people have a detailed discussion with their physician regarding the potential risks and benefits of undergoing a baseline CT scan:

- Any smoker or former smoker over age 50 with a greater than 10 pack year history of cigarette smoking. (A pack year is equal to one pack a day for one year);
- Any adult with significant exposure to cigarettes and a first degree relative (mother, father, sister, brother, son or daughter) who was diagnosed with lung cancer before age 50.

The following groups should also consider a discussion about screening with their doctors:

- Veterans who had active duty on submarines, in Vietnam or the Gulf War, and had exposure to asbestos, nuclear propulsion, herbicides, battlefield emissions or other carcinogens;
- Past and present employees in munitions plants (who may already be eligible for free screening under the Department of Energy’s Worker Health Protection Program);
- People exposed regularly to second-hand smoke (i.e. airline personnel, hospitality industry workers), or radon, or those working with asbestos or other known carcinogens.

LCA WILL CONTINUE TO ADVOCATE FOR:

- Congressional enactment of legislation on quality standards for credentialing of LDCT scanning centers and quality standards for scanning sites, equipment, personnel, data collection and pooling of data to permit the establishment of the most effective and economical approach to establishing a national lung cancer screening program.
- Pilot screening and early disease management programs based on the I-ELCAP protocols within TRICARE, VA, and Medicare, to transfer, train and refine best practices for optimal screening practice.
- Development of computer assisted diagnosis (CAD) software programs to make CT screening for lung cancer as efficient and cost-effective as CT screening of checked luggage, which the Transportation Security Agency (TSA) developed expeditiously through a meaningful commitment of federal and private funding.
- Assistance of the National Institute of Science and Technology (NIST) in developing measuring tools to facilitate CAD and quality controls for CT screening standards.
- Orphan Drug-type incentive program to expedite the development of drugs for pre-cancerous lung conditions and for more effective early and late stage drugs and targeted therapies.
- Other measures to ensure co-development of CT screening as a combined imaging platform for tobacco-induced heart disease as well as COPD/emphysema to maximize public health benefit while achieving cost efficiencies.

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WHERE TO GET A CT SCAN

For those who choose to receive a scan, we recommend that it be performed at centers that have a multi-slice scanner (preferably 16 slice or better), experience with CT screening, a high volume of lung scans and a well developed protocol, such as the I-ELCAP protocol, for reading scans. In addition, a multi-disciplinary team of doctors should review the scan. Centers that meet such qualifications include:

- All sites participating in the International Early Lung Cancer Action Program (I-ELCAP) which can be found at <http://www.ielcap.org/members.htm>
- Sites recognized by the National Cancer Institute as Cancer Centers or Comprehensive Cancer Centers which can be found at: <http://www.cancer.gov/cancertopics/factsheet/NCI/cancer-centers>
- NCI Centers hosting Specialized Centers of Excellence at the following: <http://spores.nci.nih.gov/current/lung/lung.html>
- Individual sites (which will also be updated regularly) such as:
 - Rush University Medical Center, Chicago IL
 - Eppley Cancer Center, Omaha NE
 - NYU Comprehensive Cancer Center, NY
 - Ann Arundel Medical Center, Annapolis MD

The Lung Cancer Alliance (www.LungCancerAlliance.org) is the only national non-profit organization solely dedicated to patient support and advocacy for people living with, or at risk for, lung cancer. As the number one cancer killer, lung cancer will kill more than 160,000 Americans this year alone, causing more deaths than breast, prostate, colon, liver, kidney cancers and melanoma combined.

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