Professor Fred R. Hirsch: together, our voices are much stronger than individually—a special interview about the 2017 Lung Cancer Awareness Month campaign

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Editor's note

As is reported by the *GlobeNewswire* in Nov. 2017, "*The Lung Cancer Awareness Month Coalition (LCAMC), a group of more than 20 research and advocacy organizations from around the world focused on thoracic cancers, announced the launch of the 2017 Lung Cancer Awareness Month with a panel event at the National Press Club in Washington, D.C. Panelists outlined the most pressing topics in lung cancer prevention and treatment, and their priorities for this November, focusing on better implementation of lung cancer screening guidelines, expanding knowledge of treatment options and growing patient participation in decision making and in clinical trials*" (1). To share more about the Lung Cancer Awareness Month campaign, we have made a topical interview with Prof. Fred R. Hirsch (*Figure 1*), the CEO of the International Association for the Study of Lung Cancer (IASLC), which leads the Coalition.

Figure 1 Prof. Fred R. Hirsch—professor of Medicine and Pathology in University of Colorado; the CEO of the International Association for the Study of Lung Cancer (IASLC), which leads the Coalition.

Interview

TLCR: What is the significance of hosting the Lung Cancer Awareness Month campaign? How far away are we from the goals that you hope to achieve?

Prof. Hirsch: The goal of the LCAMC is to unite various lung cancer advocacy organizations in a common campaign each November to generate awareness for the disease burden and to help improve patient outcomes. While each of our organizations is making a great effort individually, it's important that we come together, combine our resources and focus on common objectives. Together, our voices are much stronger than individually—and we have a unique opportunity each November to shine light on this disease, which continues to be the deadliest of all cancers.

This year, the Coalition is focused on increasing awareness for the exceptional medical advancements occurring in lung cancer diagnosis and treatment, as well as some of the challenges that we still need to overcome. While many in the scientific community are aware of our successes, it's important that the public, especially patients and all physicians, know about the headway being made. For instance, we need to ensure that patients and physicians are aware of the latest clinical trial results, helping to increase the implementation of screening guidelines, and learning about new immunotherapy and targeted therapy treatment options. We've seen incredible progress in all of those areas in recent years, but there is still a long way to go.

Unfortunately, we've known that the stigma surrounding lung cancer has a negative impact on the amount of research funding that the disease receives. While lung cancer is responsible for about 32 percent of all cancer deaths, the disease receives only 10 percent of cancer research funding. It is crucial to increase funding so that we can push for fuller implementation of screening guidelines, as well as continue to develop new treatment options and do clinical trials, which is crucial for further treatment progress.

TLCR: The LCAMC in 2017 has discussed the need for greater implementation of screening guidelines, which are incredibly effective at diagnosing lung cancer early. What is the major problem that hinders the implementation of screening? What's your suggestion to overcome these obstacles?

Prof. Hirsch: Following the National Lung Screening Trial (NLST) landmark study, which showed the effectiveness of lung cancer screening using low-dose CT screens, the US Preventive Services Task Force created screening guidelines. The organization recommends that patients aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years should be screened. The creation of these guidelines was a major step in reducing the lung cancer mortality rate, however, implementation has been slower than we'd like. More education of both physicians and the public about the guidelines is needed so that we can ensure high-risk individuals are being screened. Catching the disease early is key to effectively treating it. We also need to encourage the adoption of guidelines globally, as many countries have yet to introduce standards.

Another contributor to slow implementation may be the high false-positive rate that can occur with low-dose CT scans. Because CT scans can detect nodules that are not malignant, there is additional follow up diagnostic work and emotional distress that can be caused by a false-positive result. Understandably, this may cause physicians to be hesitant to recommend low-dose CT scans. We just need to educate doctors and patients about false-positives and to prepare them before any diagnosis is made.

TLCR: Looking at the screening guidelines implemented in US at present, is there any work should be further done to improve the screening technology?

Prof. Hirsch: The US Preventative Services Task Force recommends that lung cancer screening use low-dose CT scans for defined-risk populations. These guidelines came about following the NLST study, which showed a reduction in lung cancer mortality of 20% for low-dose CT scans versus X-ray scan. Unfortunately, despite these encouraging results, the screening guidelines have not been fully implemented.

In addition to increasing the implementation of the existing US guidelines, there is also a lot of work to be done in improving the screening technology itself. In particular, we must address the high false-positive rate for screen-detected nodules. Up to 66 percent of participants enrolled in low-dose CT scans have at least one nodule, the large majority of those being benign. There are a variety of specific nodule characteristics, such as shape, size and volume growth, that have been shown to be associated specifically with lung cancer. Some studies have tried to combat the high false-positive rate by incorporating these characteristics into their nodule management protocol. There have been some encouraging results. The Dutch-Belgian lung cancer screening trial (NELSON), which used volume measurements, led to a 1.7 percent false positive rate, much lower than the 26.6 percent rate produced by the NLST. However, more research is needed to improve the screening practices and guidelines.

TLCR: Besides smoking, what are the other major causes of lung cancer? And how should people work to reduce the exposure of the causes?

Prof. Hirsch: One of the greatest misconceptions about lung cancer is that only people who smoke get the disease. It's simply not true, and that assumption has created a lot of stigma that is very harmful to research and funding efforts and, most importantly, patients' wellbeing. There are many other potential causes of lung cancer, including exposure to radon, air pollution and other environmental factors, as well as a genetic history.

Radon exposure is estimated to be the second leading cause of lung cancer. Radon is a naturally occurring radioactive gas that can cause the disease when individuals are exposed to it high quantities. Individuals can take action to reduce their risk by testing their homes for high radon levels and, when needed, making repairs to decrease the level of radon.

TLCR: Thank you so much, Prof. Hirsch. Hopefully, stronger awareness on lung cancer will be raised among the public through this Lung Cancer Awareness Month campaign.

Acknowledgements

None.

Footnote

Conflicts of Interest: The author has no conflicts of interest to declare.

References

1. Global Lung Cancer Awareness Month Coalition Kicks-Off 2017 Awareness Month. Washington: GlobeNewswire, 2017. Available online: https://globenewswire.com/news-release/2017/11/06/1175303/0/en/Global-Lung-Cancer-Awareness-Month-Coalition-Kicks-Off-2017-Awareness-Month.html

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