



# Delays in care and the failure of the lung cancer care continuum

**Amit Bobby Mahajan**

Interventional Pulmonology, Department of Surgery, Inova Heart and Vascular Center, Inova Schar Cancer Institute, Inova Fairfax Hospital, Falls Church, VA, USA

*Correspondence to:* Amit Bobby Mahajan, MD, FCCP, DAABIP. Interventional Pulmonology, Department of Surgery, Inova Heart and Vascular Center, Inova Schar Cancer Institute, Inova Fairfax Hospital, Falls Church, VA, USA. Email: Amit.Mahajan@inova.org.

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As an interventional pulmonologist at Inova Fairfax Hospital, I diagnose and tell people that they have lung cancer every day. Unfortunately, lung cancer has the highest mortality of any cancer, greater than both breast and prostate cancer combined (1). Despite being the deadliest cancer, the process to diagnose and treat lung cancer is incredibly slow. In the United States, patients may wait up to 98 days from referral to treatment (2). This drawn-out process is often a result of a flawed referral system and suboptimal diagnostic testing. As physicians we can do better.

Patients with lung cancer often feel as though their diagnosis was delayed. Patients are shuffled through the medical system, meeting multiple physicians, and undergoing various tests to diagnose their lung cancer. The multiple pathways to achieve a diagnosis are not standardized. Without an understanding of the modern health system, patients are often left to fend for themselves. Without an informed approach, the diagnosis or treatment of lung cancer can be significantly delayed without good cause.

More often than I would like to admit, a patient with potential lung cancer is referred to the wrong doctor. It sounds ridiculous, but it is the truth. This is not done maliciously, but due to a lack of referring physicians' understanding of the diagnostic process. What does a primary care physician (PCP) do when there is a patient who might have lung cancer? Send them to a cancer doctor. Unfortunately, that is not always correct. When they get to the cancer doctor, the patient is told "a biopsy is needed before treatment can start". So, the patient gets sent to a different doctor. The next doctor must perform a procedure to determine the diagnosis and additional imaging may

be needed. Six to eight weeks may pass before a surgery or systemic therapy is initiated. During this time, the emotional and mental toll on patients is dreadful and the risk of cancer spread increases.

Despite the roundabout pathway for patients to reach a diagnosis and treatment plan, there are ways to take control and facilitate lung cancer care. The most important intervention to facilitate care rates of screening for patients at high-risk for lung cancer. Lung cancer screening with a low-dose CT scan has shown to improve survival from lung cancer by 20% (3). This is true because screening identifies lung cancers at an early stage when it is curable. Entering into a screening program also triages a patient to the correct physician for care immediately. Unfortunately, rates of screening for lung cancer are abysmal. Only about 5% of patients who are eligible for lung cancer screening in the United States are screened (4). Nationally, screening programs are often unknown to patients and are underutilized by physicians. Believe it or not, physicians may not even know that lung cancer screening is available in their area. High-risk patients include those who are heavy smokers between the age of 50 to 77 years old and are actively smoking or have quit in the last 15 years are considered high risk and are covered by Medicare and most commercial health insurance carriers for lung cancer screening. Qualifying patients should inquire about lung cancer screening to their PCP or seek out a screening center themselves on the internet.

Finally, after the diagnosis of lung cancer is made, patients should find an oncologist or surgeon that practices the most up-to-date, minimally invasive therapies. The world of cancer treatment, surgical and medical, have evolved leaps and bounds in the last decade. Targeted

therapies that focus on a specific gene mutation along with medications that activate your own immune system to attack lung cancers are incredibly effective and often have fewer side effects than traditional chemotherapy. Additionally, robotic surgery allows for a minimally invasive approach to removal and cure of lung cancers with small incisions and expedited recovery. Unfortunately, typical referral patterns are hard to break for referring physicians. Often, these patterns are geared towards a specific oncologist or surgeons because of historical relationships rather than the most effective and modern care.

When patients are dealing with lung cancer, trying to navigate the medical system only increases frustration and helplessness. Luckily, physicians have the ability improve lung cancer care by improving communication. Platforms for communication, such as email and electronic medical based secure chats are ways to exchange patient information safely. Expedited referrals and communication can ensure that the correct physicians are seen, and appropriate tests are obtained. Cancer centers are also effective in facilitating care. Cancer centers house multiple, disease specific physicians under one roof and allow for multidisciplinary care. Without the delays that are built into the American health system, lung cancer diagnosis and treatment can be achieved faster. Physicians and patients must both advocate to achieve the best lung cancer care.

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## References

1. Siegel RL, Miller KD, Fuchs HE, et al. Cancer statistics, 2022. *CA Cancer J Clin* 2022;72:7-33.
2. Maiga AW, Deppen SA, Pinkerman R, et al. Timeliness of Care and Lung Cancer Tumor-Stage Progression: How Long Can We Wait? *Ann Thorac Surg* 2017;104:1791-7.
3. National Lung Screening Trial Research Team; Aberle DR, Adams AM, et al. Reduced lung-cancer mortality with low-dose computed tomographic screening. *N Engl J Med* 2011;365:395-409.
4. American Lung Association. State of Lung Cancer 2021.

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