UK National Screening Committee

TARGETED SCREENING FOR LUNG CANCER IN PEOPLE AGED 55 – 74 WITH A HISTORY OF SMOKING (Evidence Summary)

Consultation comments pro-forma

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Do you consent to your name being published on the UK NSC website alongside your response? **Yes**			

Section and / or page number	Text or issue to which comments relate	Comment *Please use a new row for each comment and add extra rows as required.*

	Overall document	Tenovus Cancer Care agree with the recommendations set out in the consultation and have some comments on the situation in Wales and from a Welsh perspective, as follows.
24	Table 4. Lung cancer incidence and mortality by gender and deprivation quintile, England	It is well known that there is a link between deprivation and smoking. Unfortunately, this wide gap in deprivation status is reflected in cancer statistics too. Across all cancer types in Wales 1-year survival in 2018 was 79% in the least deprived areas *vs* just 68% in the most deprived areas. The 5-year survival gap across all cancer types widens even further (67% in least deprived areas *vs* 50% in the most deprived areas). For lung cancer, which represents the greatest burden on the Welsh NHS, the number of people diagnosed in 2018 from the most deprived areas of Wales was more than double the number from the least deprived areas. Tenovus Cancer Care therefore agrees with the targeted approach to screening for lung cancer and the groups to target as set out in this document.
25	Smoking Tobacco	Smoking is still the leading cause of preventable death in Wales. Progress has been made, however, there is a clear need to increase the pace of change, build on and accelerate existing interventions as well as deliver new initiatives. Smoking cigarettes is the single biggest risk factor for lung cancer. It is responsible for more than 70% of cases. Lung cancer is the **biggest cancer killer** in

		Wales – more than breast and bowel cancer combined. It is also one of the least-survivable cancers. One-year survival rates lag slightly behind those for England and Northern Ireland. In addition, five-year relative survival for lung cancer in women in Wales is 10%, which is **below the average for Europe** (16%). In men the survival rate is 5%, which is also below the average for Europe (12%). With the time lag between smoking prevalence and lung cancer rates, Tenovus Cancer Care agree with the target age range as recommended as 55 -74 within the document.
29	Contextual question 2. What is the accuracy of risk assessment algorithms and/or low dose computed tomography to predict/detect lung cancer?	Tenovus Cancer Care agrees with what has been outlined in this section and agrees that there are wider factors such as deprivation, gender, ethnicity etc. that should be considered in who should be targeted for lung cancer screening. There is an important group of people missing from this. People who have experienced second-hand smoke are at high risk of developing lung cancer. There is a wealth of evidence to show that passive smoking can be more dangerous than smoking first-hand. There will be a lot of people that will go on to develop lung disease and lung cancer as a result of their exposure to second-hand smoke and these people will not have the opportunity to be picked up on this screening programme. These people are also more likely to experience health inequalities.

		We understand that it would be difficult to pick this group of people up without blanket screening for lung cancer and that targeted screening is the priority. We therefore highlight the importance of further national campaigns to raise awareness of the dangers of passive smoking, historical and present, the symptoms of lung cancer and importance for people to get themselves checked out and how they can do this. We recommend that there also be a focus on lung cancer not being a death sentence and how treatable lung cancer is when it is caught early.
37-43	What is the cost effectiveness of screening programmes for the detection of lung cancer using low dose computed tomography in individuals at increased risk, compared with no screening? What is the cost effectiveness of different strategies using low dose computed tomography screening (e.g., different intervals, use of risk algorithm, etc.)? (UK NSC criterion 14)	Screening those at a high risk provides the chance to also prevent and treat a range of tobacco-related illnesses. Additionally, it provides the opportunity to offer access to care for individuals who could be otherwise stigmatised when it comes to health equality and accessing healthcare within society. Combining CT screening with smoking cessation and management of cardiac care and chronic obstructive pulmonary disease would ultimately improve the cost-effectiveness of lung cancer screening.
14	The evidence summary 4. Review question: What is the clinical effectiveness of screening programmes for the detection of lung cancer using low dose computed tomography in individuals at increased risk, compared with no screening? Sub- question: What is the clinical effectiveness of different strategies using low dose computed	Overdiagnosis (defined as the detection of cancer that would not otherwise have become clinically apparent) can be a feature of screening, which by definition seeks to identify disease in people that do not show obvious symptoms. There is a risk for overdiagnosis when screening for lung cancer, including with the use of low dose computed tomography. Estimating this diagnosis is difficult, but given the prevalence lung cancer in Wales and the UK and the subsequent high number of deaths,

	tomography screening (e.g. different intervals, use of risk algorithm, etc.)?	Tenovus Cancer Care agrees that this is an acceptable risk because the benefits will outweigh any potential negative effects. However, capturing true level of overdiagnosis in lung cancer screening trials should be considered, such as post-screening follow-ups for all those that participate. This evidence could help to mitigate potential diagnosis in future screening programmes and should be shared with the wider global health community. Tenovus Cancer Care also recommends that clear advice and support be given to people that participate in lung cancer screening so that they fully understand this, and any other potential risks and that staff undertaking the screening should be appropriately trained to have those conversations with people.
	Overall document	There are a wealth of charities and community-based organisations across Wales and the UK that can support those that would be invited to and participate in lung cancer screening. For example, Tenovus Cancer Care provides counselling and benefits advice, along with many other opportunities to have a voice in the issues that affect them the most. Overall wellbeing and support is an important part of people's recovery/quality of life and management of symptoms. Tenovus Cancer Care recommends that all lung cancer screening programmes across the UK incorporate this support, including signposting to and, where possible, engagement with third sector and community-based services that can provide this type of support. In addition, smoking and its

		associated diseases, including lung cancer are heavily stigmatised. Third sector and community-based organisations are knowledgeable on this and have experienced staff to engage those that are seldom heard or may experience barriers to participation and stigma. Tenovus Cancer Care therefore recommends also suggesting organisations that can support, and the ways in which they can support at both invitation and screening stages (as well as for those that are identified as having lung cancer). This may also help to reduce barriers to participation. Profile of risk factors for non-participation in lung screening should be identified, along with strategies to make lung cancer screening more appealable (such as focusing on the rates of survival and recovery, quality of life, available support without judgement that can be accessed locally/easily to them. Tenovus Cancer Care recommends that we collectively no longer refer to people as 'hard to reach' as this places the blame on people, when it is up to services to find ways to make it easier for people to hear about and engage with the support that is available to them. For example, 'seldom heard' or 'people that may face barriers, such as those who experience…'

Please return to the Evidence Team at screening.evidence@nhs.net **by 08 June 2022**