

in other locations around the world, and intrigued by multiple possibilities to further expand it. ■

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Improving Lung Cancer Screening Uptake

To the Editor:

The recent article by Quaife and colleagues (1) and the accompanying editorial by Burnett-Hartman and Wiener (2) report the results of the LSUT (Lung Screen Uptake Trial) from London and provide comments from Boston. The trial is important because it provides evidence that there may be ways to improve the dismal uptake of lung cancer screening, especially in higher-risk, underserved populations. The editorialists point out some differences between the United Kingdom and United States, including the important fact that patient contact came from the individual primary care physician, which is in contrast to the approach used in the United States, where many patients do not have an identifiable primary care physician. There are other important factors, including the emphasis on the “Lung Health Check” rather than

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on more narrow lung cancer screening and the absence of copays or other financial disincentives for computed tomographic scans in the United Kingdom compared with the United States. In PLUSS (Pittsburgh Lung Screening Study) (3), we have also emphasized total lung health by providing annual spirometry, and we have eliminated financial barriers by waving all copays. We have also been using the electronic health record to identify potential candidates for lung screening. As our ability to obtain more information from the low-dose computed tomographic scans by radiomic advances, we hopefully can rebrand lung cancer screening in the United States, maybe as heart and lung screening, to facilitate more widespread use. ■

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Reply to Wilson

From the Authors:

We read Wilson’s response letter to both our LSUT (Lung Screen Uptake Trial) (1) and the 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 low-dose computed tomography lung cancer screening by high-risk individuals, but the differences between the United Kingdom and United States that Wilson raises are important for how we intervene. The United Kingdom benefits from a coordinated and universal primary care system, and we appreciate that sending postal invitations directly from the individual’s primary care physician is a strategy that may not translate

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directly to the U.S. context. We also note the requirement by the Centers for Medicare and Medicaid for a separate shared decision-making session before the screening intervention in the United States. However, evidence suggests that the behavioral components of LSUT's strategy (healthcare professional endorsement and proactively inviting and arranging appointments) are the "active ingredients" that could be implemented in different ways in the U.S. 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 minimizing fear (that could lead to information avoidance and uninformed nonparticipation) 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 and colleagues' point. This includes parallels with the PLuSS (Pittsburgh Lung Cancer Screening Study) (3), which found that the prevalence of emphysema and airway obstruction increased with individual lung cancer risk. For example, work led by Ruparel and colleagues (4) found a significant proportion of undiagnosed chronic obstructive pulmonary disease and untreated coronary artery calcification (5) within our LSUT cohort, suggesting opportunities for early diagnosis of chronic obstructive pulmonary disease, instigating cardiovascular risk assessment and primary prevention. The UK taxpayer's universal healthcare system may in the future fund low-dose computed tomography screening scans, and so we would not have the financial disincentives that the United States has in this respect. However, the United Kingdom does have limited resources for subsequent healthcare 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. ■

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Airway Disease Presenting as Restrictive Impairment

To the Editor:

Eddy and coworkers (1) have earned the appreciation of pulmonary clinicians and physiologists for providing both a physiologic and an

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