Commentary: Prevention is possible: Our responsibility is real

Susan D. Moffatt-Bruce, MD, PhD, FRCSC, FACS

The authors Kamel and colleagues have put forward a very interesting paper that truly challenges us as a surgical society. They clearly articulate that although there has been existing evidence, for more than a decade, that low-dose computed tomography (LDCT) screening for lung cancer saves lives, we have a paucity of engagement, with only 1 in 15 eligible individuals for LDCT screening actually completing this preventative intervention.

When there is such clear scientific evidence that lives can be saved, there must be a complex multifactorial reason for such a low uptake. Kamel and colleagues focused on cited “potential harms” of screening as a variable that may influence uptake. This was initially unclear as to the why, but as the authors have stated, complications are often tracked and always spoken of. As outlined in the featured paper, the risk of complications in patients undergoing screening is very low and that for those who undergo screening yet turn out to not have lung cancer, almost nonexistent. This is likely a result of the standardized processes that many cancer centers have developed when faced with patients with lung nodules, including diagnostic imaging, biopsy protocols, and oncology clinical pathways. So, once within the system, after applying the appropriate LDCT parameters, which have now been expanded, the system works and has been proven to reduce lung cancer mortality. However, we need to get patients into the system.

So perhaps we need to get people’s attention by focusing on obvious complications, or the lack therein, and perhaps we talk about complications because it easier than addressing the elephant in the room: the system-level barriers to screening and preventing deaths. Have we not yet realized that through prevention, we can prevent harm? The paper by Carter-Harris and Gould is so appropriately titled: “Multi-level Barriers to the Successful Implementation of Lung Cancer Screening: Why Does It Need to Be So Hard?” There are many layers to the system and range from the patient, the providers, and overall health care system. Each one of these layers has so many barriers that we have yet to address in a holistic approach and include very real yet disjointed programs around patient and provider education, access to screening programs, and system supports for those who ultimately need lung cancer care. We have learned over the past several years that our system is fragile and one that has little-to-no equity. We have work to do as a society.

We must therefore, as a surgical society, continue to remind that through prevention we cure more patients. We must address the systems issues we have influence over and advocate for those we don’t. We must always be ready to sit at the table and think of those voices not heard; those patients we might have cured had we succeeded in prevention. This is our responsibility to remind and prevent.
References