

# Lung Cancer Screening



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# NATIONAL LUNG CANCER ROUNDTABLE

## MANAGEMENT OF LUNG NODULES AND LUNG CANCER SCREENING DURING THE COVID-19 PANDEMIC

Peter Mazzone, MD, MPH

*Cleveland Clinic*

# Where We Were

The New York Times

Opinion

## The Psychological Impact of Our Doctors and

Don't underestimate the moral impact of a ventilator.



By **Jennifer Senior**  
Opinion columnist

March 29, 2020

## 'A Heart-Wrenching on Visits Devas

To curb the risk of spreading the virus, states nationwide are banning visits to nursing homes.



## White House Airlifts Medical Supplies From China in Coronavirus Fight

Officials have teamed up with medical supply companies to speed the arrival of masks, gloves, gowns and other goods.



# Consensus Statements

1. During the COVID pandemic, consistent with CDC guidance to defer non-urgent care, it is suggested that the **initiation of screening be delayed.**
2. During the COVID pandemic, consistent with CDC guidance to defer non-urgent care, it is suggested that the **annual screening exam be delayed.**
3. Solid nodule < 8 mm: During the COVID pandemic, consistent with CDC guidance to defer non-urgent care, it is acceptable to **delay the surveillance CT scan for approximately 3-6 months.**
4. LungRADS category 3: During the COVID pandemic, consistent with CDC guidance to defer non-urgent care, it is acceptable to **delay surveillance for approximately 3-6 months.**
5. During the COVID pandemic, consistent with CDC guidance to defer non-urgent care, it is acceptable to **delay surveillance of any size pure ground glass nodule for approximately 3 to 6 months.**
6. Part-solid 6-8 mm: During the COVID pandemic, consistent with CDC guidance to defer non-urgent care, it is acceptable to **delay surveillance for approximately 3 to 6 months.**
7. Nodule risk < 10%: During the COVID pandemic, consistent with CDC guidance to defer non-urgent care, it is acceptable to **delay the surveillance CT scan for approximately 3-6 months.**

# Consensus Statements

8. Malignancy risk 10-25%: During the COVID pandemic, consistent with CDC guidance to defer non-urgent care, it is acceptable to **re-evaluate the patient with a chest CT scan in approximately 3-6 months.**
9. Part-solid lung nodule  $\geq 8$  mm: During the COVID pandemic, consistent with CDC guidance to defer non-urgent care, it is acceptable to **monitor the nodule with a chest CT scan in approximately 3-6 months.**
10. Malignancy risk 65-85%: During the COVID pandemic, consistent with CDC guidance to defer procedures and surgery when reasonable, it is acceptable to **evaluate the patient with a PET scan and/or non-surgical biopsy to insure there is a need to proceed to treatment** (surgical resection or stereotactic radiotherapy).
11. Malignancy risk  $>85\%$ : During the COVID pandemic, consistent with CDC guidance to minimize exposure to the healthcare environment, it is acceptable to **avoid further diagnostic testing and proceed to an empiric treatment decision** (i.e. surgical resection or stereotactic radiotherapy).
12. Treatment of clinical stage I non-small cell lung cancer may be delayed, consistent with CDC guidance to defer surgery when reasonable, after **taking into consideration an assessment of the size of the cancer, growth rate of the cancer** (if serial imaging is available), **FDG/PET avidity of the primary tumor, patient values, and the general health and fitness of the patient.**





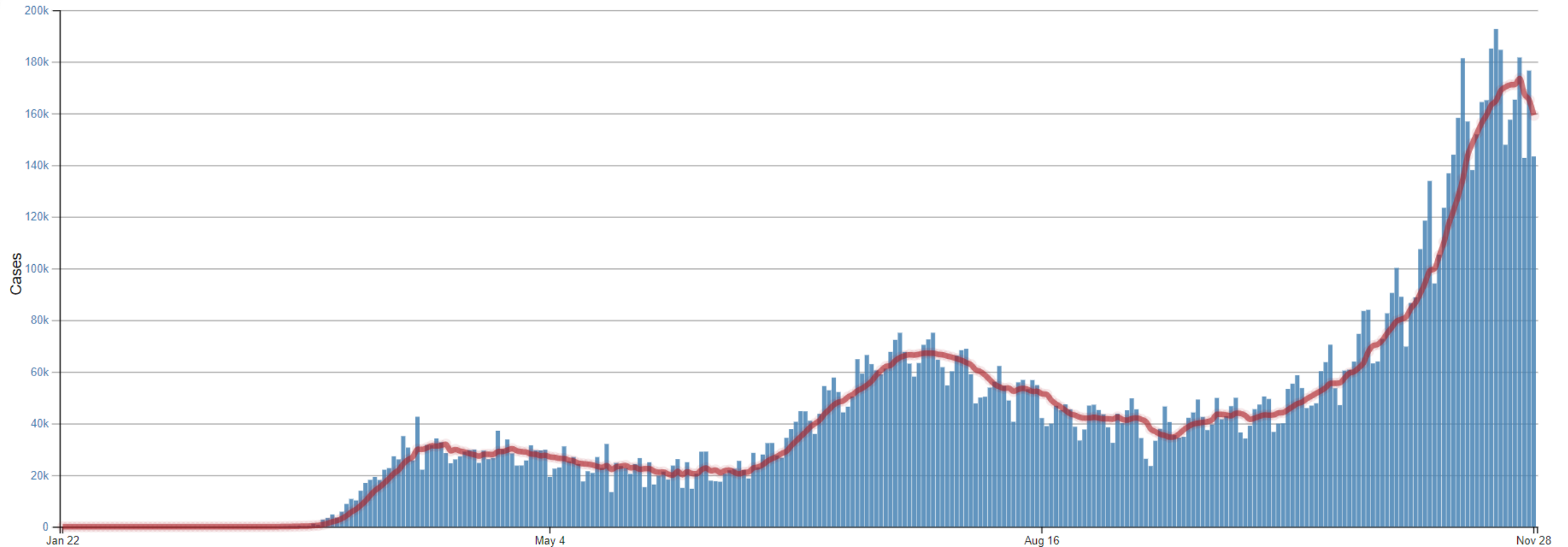
# Individualize Decisions

- The authors of the consensus statement recognize that our statements **should not be interpreted as one-size fits all**, and that **what is appropriate now will change over time**.
- Application of a general assessment to an individual patient requires the clinical **judgment of the management team**.
- In addition to considering **patient factors and values**, we attempted to highlight that local factors, such as the **prevalence of COVID in the community**, the **availability of rapid COVID testing**, the **adequacy of resources** (personnel, imaging equipment, personal protective equipment), local policies, and the **presence of other care delivery sites that are less impacted by COVID**, should be considered when making individual decisions.



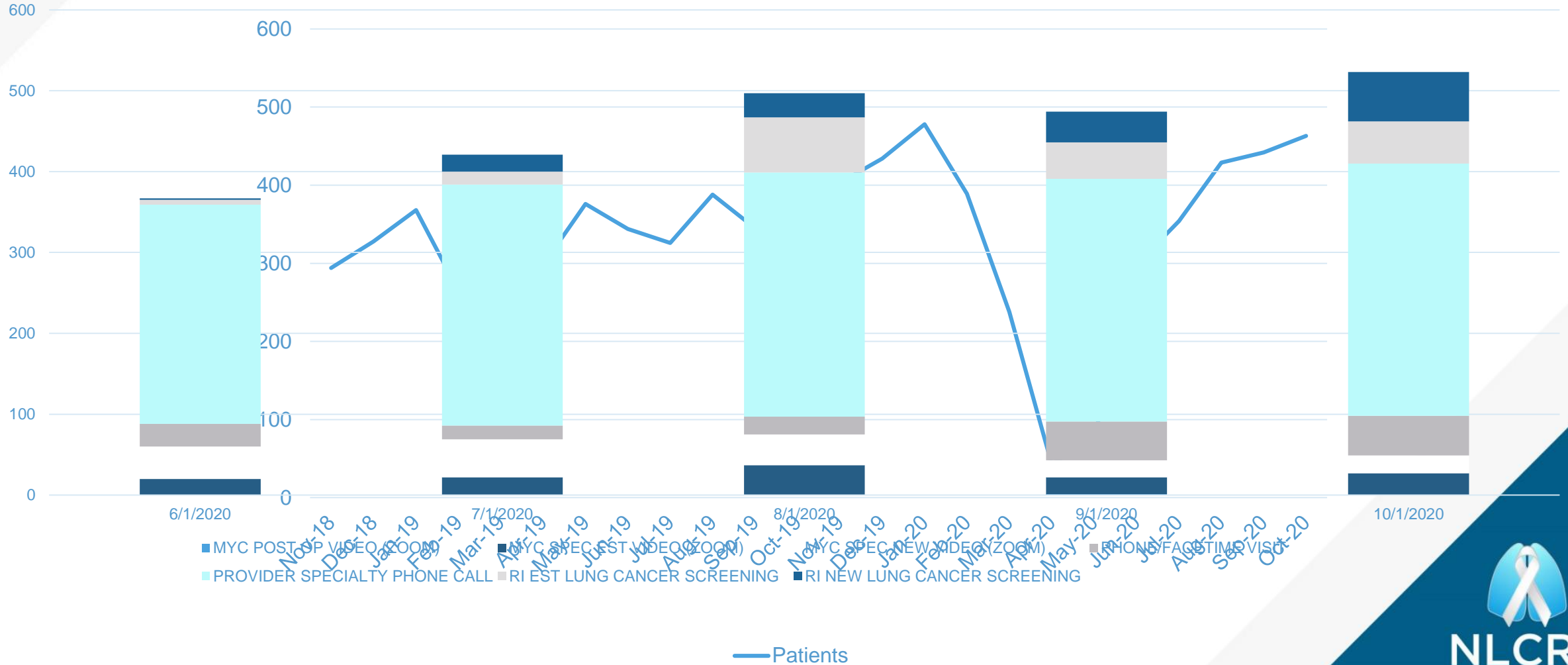
# Current Status

Daily Trends in Number of COVID-19 Cases in the United States Reported to CDC



# Program Volume and Changes

LC/LCS Provider Virtual Appointments  
Patient Growth  
Jun - Oct 2020





# Did you close or decrease enrollment of new patients to your screening program?

Program	March	April	May	June	July	August
1						
2*						
3						
4						
5						
6						
7						
8						
9						
10						
11						

\* = international center, recruiting for screening trial



# Did you delay annual screening in your screening program?

Program	March	April	May	June	July	August
1						
2*						
3						
4						
5						
6+						
7						
8						
9						
10						
11						

\* = international center, recruiting for screening trial; + = no formal policy

# Did you delay surveillance imaging for category 3 lung nodules?

Program	March	April	May	June	July	August
1						
2*		■	■			
3	■	■	■	■	■	■
4						
5						
6+						
7+						
8						
9	■	■	■	■	■	
10+						
11	■	■	■	■	■	■

\* = international center, screening trial; + = no formal policy; some with few due



# Current status of your screening program

Program	Annual/New		Caught Up		Volumes	
1						
2*						
3						
4						
5						
6						
7						
8						
9						
10						
11						

\* = international center, screening trial



# Changes to program structure

- **Telehealth** – all programs that responded are using telehealth much more often for SDM and follow-up, less clear in decentralized programs
- **Number of screening sites** – none have closed, some try to schedule at non-COVID imaging centers
- **Spacing of LDCT schedule** – 7 or 9 responses indicated an attempt to space the LDCT scans further apart, automated check-in, extended hours in imaging, increased antiseptic use
- **Other thoughts**
  - Concern about staffing due to COVID-19 illness of the providers and techs
  - Many patients still choosing not to return for fear of exposure
  - Mixed messaging – more marketing that it is safe to come in and preventive care is important, not safe to have someone with you or a visitor for a hospitalized patient
  - Referral rate for tobacco cessation program down as was tied to the in-person SDM visit
  - Motivated a program to transition from de-centralized to hybrid
- No closures due to **the recent surge.**

Thank You







# NATIONAL LUNG CANCER ROUNDTABLE

## VA & GO<sub>2</sub> FOUNDATION FOR LUNG CANCER COLLABORATION

Leaving No Veteran Behind – Lung Cancer Screening

Anita McGlothlin

*GO<sub>2</sub> Foundation*

# Disclosures

Nothing to disclose

# GO2 FOUNDATION FOR LUNG CANCER



- Principal offices in San Francisco Bay Area and Washington, DC
- Dedicated to saving, extending, and improving the lives of those vulnerable, at risk, and diagnosed with lung cancer
- 220,000 “members” strong
- National Board of Directors
- National Scientific Leadership Board
- National Ambassador Council





## Partnership Goal: *To improve care and outcomes for Veterans at risk for lung cancer by increasing early detection and treatment.*

- **MOU Signed Feb. 2020**
- Learning Collaborative
- Online/Peer GO<sub>2</sub> learning networks – Excellence Exchange
- Virtual Workshop – during our Centers of Excellence Summit–
- Free supports, tools, training and materials, as well as communication platforms that are both professional facing and patient facing.



U.S. Department  
of Veterans Affairs

**News Release**  
Office of Public Affairs  
Media Relations  
Washington, DC 20420  
(202) 461-7600  
www.va.gov

FOR IMMEDIATE RELEASE  
June 16, 2020

### **VA and GO<sub>2</sub> Foundation for Lung Cancer partner to improve outcomes for Veterans at risk of lung cancer**

**WASHINGTON** — The U.S. Department of Veterans Affairs (VA) announced today it has partnered with nonprofit [GO<sub>2</sub> Foundation for Lung Cancer](#) to increase awareness about lung screening options and improve outcomes for Veterans impacted by lung cancer.

This partnership allows for VA and GO<sub>2</sub> to leverage resources, programs and services available through GO<sub>2</sub> Foundation's national network of more than [750 centers of excellence](#).

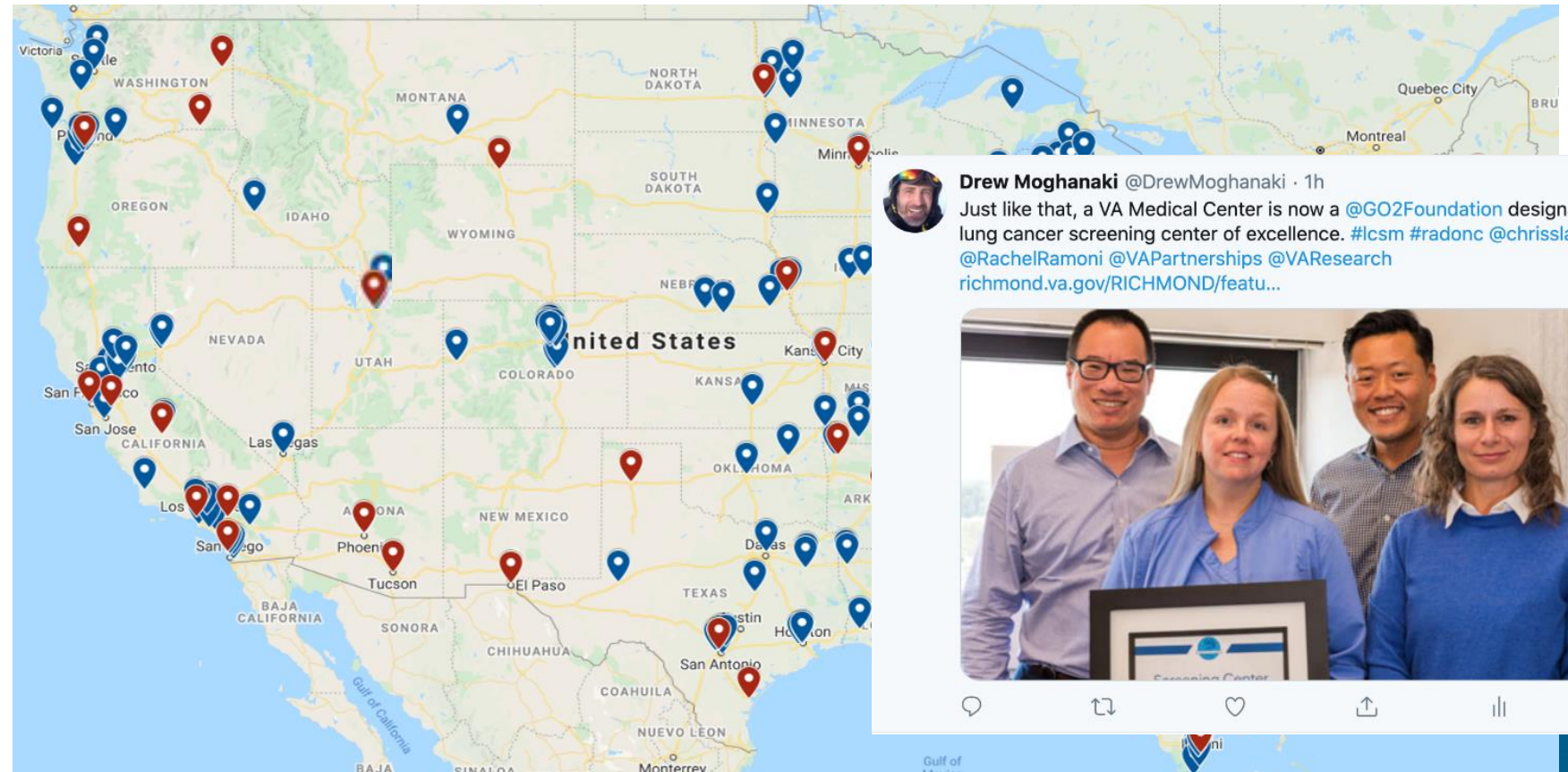
“Research and initiatives to ensure access to early detection and treatment will greatly improve the care of Veterans with lung cancer,” said VA Secretary Robert Wilkie. “This public-private partnership will help expand the array of services that are currently available within VA and increase public awareness about Veteran-specific conditions that place Veterans at greater risk for lung cancer.”

VA diagnoses 7,700 Veterans with lung cancer each year and an estimated 900,000 remain at risk due to age, smoking and other environmental exposures during and after military service.

“This important milestone allows us to share with VA our many years of experience developing best practices for lung cancer screening and care to help improve outcomes for Veterans impacted by this disease,” said CEO, Co-founder and President of GO<sub>2</sub> Foundation Laurie Fenton Ambrose.

# SCOEs and VA Centers offering LCS

- 9M Veterans enrolled in the VA Healthcare
- 15M Veterans at large in US support VA Office of Community Care
- Help Veterans identify high-quality screening centers
- 774 GO<sub>2</sub> Foundation Screening Centers of Excellence 45 states plus DC
- 75 VA Medical Centers – Providing LCS



**Blue** = GO<sub>2</sub> Screening Centers of Excellence (SCOEs)

**Red** = VA Medical Centers Providing LC Screening





# Veterans and Lung Cancer

*"This partnership [with GO2 Foundation] will enhance the array of services available through the VA and expand public awareness about Veteran-specific conditions that place Veterans at greater risk for lung cancer."*  
- Robert Wilkie, Secretary, Department of Veterans Affairs (VA)

## Advocacy

- [Our Legislative Priorities](#)
- [How to Become an Advocate](#)
- [Take Action](#)
- [Impact](#)
- [Lung Cancer Caucus](#)
- > [Veterans](#)
- [Policy Letters](#)
- [National Ambassador Council](#)

Men and women who served in the military, especially those who served in combat, are at higher risk for lung cancer than civilians. We are committed to ensuring that Veterans get the help, support, information and access to care they need to detect the disease at early curable stages, improve quality of life, and advance research and advocacy efforts to save lives.

Our recently announced partnership with the U.S. Department of Veterans Affairs (VA) will help us expand our reach into the Veteran community. [Click here to read the full press release.](#)

### Screening Saves Lives

Learn about lung cancer screening and coverage.

**SCREENING SAVES LIVES >**

### Partnership with the Department of Veterans Affairs

We're working together to improve care and outcomes for Veterans.

**OUR PARTNERSHIP >**

### Advocacy & Research

Advocacy efforts that support research and access to care for our high risk Veterans.

**ADVOCACY & RESEARCH >**



"As a retired soldier, it wasn't until I joined the Board of GO2 Foundation that I became aware of our elevated risk for the disease. I encourage you to get the facts about lung cancer screening and access GO2 Foundation's professional and caring HelpLine staff who are ready to answer questions and refer you to responsible screening and care near you."

**-Rick Sherlock**  
GO2 Foundation Board Member and retired Major General of the United States Army







Drew Moghanaki, MD,  
MPH



Jane Kim, MD, MPH



Sheila Ross



Laurie Fenton  
Ambrose

# Thank You!

**Anita K. McGlothlin**

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**NLCRT**  
NATIONAL LUNG CANCER ROUNDTABLE

Thank You





# NATIONAL LUNG CANCER ROUNDTABLE

## THE FIRST MILLION SCREENS

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Charleston, SC  
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# 5 Takeaways

- Nearly 90% meet eligibility criteria
- The demographics of those being screened significantly differ from the 8 million eligible Americans
- Adherence to annual screening is unacceptably low
- The cancer detection rate is half of NLST
- Cancer stage matches NLST

# How good are we at screening those that meet eligibility criteria?

- 88% meet USPSTF criteria
- Among those not meeting USPSTF criteria (150,773)
  - **50%** were former or current smokers <30 pack years
  - **13%** were former smokers with 30+ pack years, but quit more than 15 years ago
  - **12%** were <55 years
  - **10%** were current smokers without info
  - **2%** were >80 years
  - **2%** were never smokers

**\*Note 40,426 of these would be eligible under new proposed 2020 USPSTF criteria**



## Comparison of first million screens to the 8 million Americans eligible for screening

	Screened in LCSR	Screened in LCSR v Adults Eligible in U.S.		
<b>No.</b>	1,052,591	Observed to Expected Ratio(OER) <sup>d</sup>		
	%	OER	95%CI	
<b>Females</b>	48.3	<b>1.16</b>	1.09	1.24
<b>Male</b>	51.7	0.89	0.85	0.93
<b>55-64 y</b>	53	0.93	0.89	0.98
<b>65-74 y</b>	39.9	<b>1.15</b>	1.07	1.24
<b>75-80 y</b>	7.1	0.88	0.73	1.06
<b>Black</b>	<b>7.4</b>	1.10	0.89	1.35
<b>Hispanic</b>	2.2	<b>0.63</b>	0.47	0.84
<b>College educated</b>	16.3	<b>1.23</b>	1.07	1.42
<b>Current smoker</b>	61.4	<b>1.17</b>	1.11	1.23
<b>Former smoker</b>	38.6	0.81	0.75	0.87

# Demographic Implications

- **More woman being screened**
  - Expected given trends with other preventive care services
  - Potentially better outcomes - data from NELSON and NLST
  - To increase uptake need focused messages to men
- **Older persons**
  - May be related to insurance (Medicare)
  - Implications for outcomes – risk of cancer higher, risk of harms higher benefit may be lower
- **More current smokers**
  - Former smokers - Out of sight out of mind
  - Identifying former smokers eligibility in EMR may be difficult
  - Implications for outcomes – risk of cancer higher, risk of harms higher
  - Education on eligibility to public and PCP's and ease of identifying former smokers in EMR

# Demographic Implications

- **Better educated**
  - Greater access to screening services
  - Less likely to need screening as smoking rates significantly lower
- **Better insured**
  - Private (49%), Medicare (43%), Medicaid (7%) self pay (1%)
  - Implications for uptake: highest smoking rates in uninsured
- **Race**
  - Blacks being screened at appropriate level
  - Hispanics much lower than expected

# Adherence

- Defined as eligible persons with Lung-RADS  $\leq 2$  returning for an annual screen within 11-15 months
- 691,216 eligible, 132,408 (19%) performed
- Predictors of non-adherence:
  - Blacks .79 (95%CI .76-.82)
  - Hispanics .69 (95%CI .60-.70)
  - < high school degree .88 (95%CI .82-.95)
  - Self pay/uninsured .45 (95% CI .40-.50)
  - Current smoker .82 (95%CI .81-.83)
  - Residency in the South/West .72 (95% CI .72-.74)
- **Implications:** Emphasis on system level, physician level, patient level interventions: This is not a “one and done” test.

# Outcomes

- **Cancer diagnoses**
- 5882 cancers among 1,058,459 baseline screens (CDR 0.56%)
- 718 cancers among 277,958 annual screens (CDR 0.34%)
- **Lung-RADS findings;**
  - 1(40%), 2 (43%), 3 (10%), 4 (7%)
- **Proportion of cancers by Lung-RADS designation**
  - Lung-RADS 1 (1%), 2 (2%), 3 (6.6%), 4A (21%), 4B (42%), 4X (27%)
- **Cancer Stage**
  - Stage I (40%), II (9%), III (15%), IV 11%)
- **Implications**
  - Lung-RADS works
  - Stage shift similar to NLST
  - CDR low – underreporting? Missed evaluations? Poor adherence?

# Summary

- Registry provides a roadmap for further research and improved implementation
  - Link with other databases to assess validity and study outcomes not captured in the registry
  - Target groups not currently being screened
  - Need strategies to increase adherence
  - Need multipronged approach to overcome disparities in screening



# Collaborators

- Lenka Goldman
- Judy Burleson
- Michael Gould
- Ella Kazerooni MD
- Peter J. Mazzone, MD, MPH
- Patricia Rivera MD
- Paul Doria-Rose
- Lauren S. Rosenthal, MPH
- Michael Simanowith
- Robert A. Smith, PhD
- Nichole T. Tanner, MD, MSCR
- Stacey Fedewa, PhD

Thank You







## **NATIONAL LUNG CANCER ROUNDTABLE**

# **USPSTF LUNG CANCER SCREENING GUIDELINES**

**Ella A. Kazerooni, MD, MS, FACR, FSABI, FCCP**  
**Chair, National Lung Cancer Roundtable**  
**Professor of Radiology & Pulmonary Medicine**  
**University of Michigan**

# USPSTF Lung Cancer Screening Guideline

- December 2013 Revision
- Draft Revision posted July 2020 with public comment
- Review proposed changes and potential impact

# USPSTF LCS Guideline: 2013

## Screening for Lung Cancer

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This topic page summarizes the U.S. Preventive Services Task Force (USPSTF) recommendations on screening for lung cancer.

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### Current Recommendation

Release Date: December 2013

- **The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.**

Grade: [B recommendation](#).



U.S. Preventive Services Task Force

# USPSTF LCS Guideline: 2013

CLINICAL GUIDELINE

Annals of Internal Medicine

## Screening for Lung Cancer: U.S. Preventive Services Task Force Recommendation Statement

Virginia A. Moyer, MD, MPH, on behalf of the U.S. Preventive Services Task Force\*

**Description:** Update of the 2004 U.S. Preventive Services Task Force (USPSTF) recommendation on screening for lung cancer.

**Methods:** The USPSTF reviewed the evidence on the efficacy of low-dose computed tomography, chest radiography, and sputum cytologic evaluation for lung cancer screening in asymptomatic persons who are at average or high risk for lung cancer (current or former smokers) and the benefits and harms of these screening tests and of surgical resection of early-stage non-small cell lung cancer. The USPSTF also commissioned modeling studies to provide information about the optimum age at which to begin and end screening, the optimum screening interval, and the relative benefits and harms of different screening strategies.

**Population:** This recommendation applies to asymptomatic adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.

**Recommendation:** The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. (B recommendation)

*Ann Intern Med.* 2014;160:330-338.

[www.annals.org](http://www.annals.org)

For author affiliation, see end of text.

\* For a list of the members of the USPSTF, see the **Appendix** (available at [www.annals.org](http://www.annals.org)).

This article was published online first at [www.annals.org](http://www.annals.org) on 31 December 2013.



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# USPSTF LCS Guideline: 2013

**Annals of Internal Medicine**



## SCREENING FOR LUNG CANCER CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

<b>Population</b>	Asymptomatic adults aged 55 to 80 y who have a 30 pack-year smoking history and currently smoke or have quit smoking within the past 15 y
<b>Recommendation</b>	Screen annually for lung cancer with low-dose computed tomography. Discontinue screening when the patient has not smoked for 15 y. Grade: B
<b>Risk Assessment</b>	Age, total cumulative exposure to tobacco smoke, and years since quitting smoking are the most important risk factors for lung cancer. Other risk factors include specific occupational exposures, radon exposure, family history, and history of pulmonary fibrosis or chronic obstructive lung disease.
<b>Screening Tests</b>	Low-dose computed tomography has high sensitivity and acceptable specificity for detecting lung cancer in high-risk persons and is the only currently recommended screening test for lung cancer.
<b>Treatment</b>	Non-small cell lung cancer is treated with surgical resection when possible and also with radiation and chemotherapy.
<b>Balance of Benefits and Harms</b>	Annual screening for lung cancer with low-dose computed tomography is of moderate net benefit in asymptomatic persons who are at high risk for lung cancer based on age, total cumulative exposure to tobacco smoke, and years since quitting smoking.
<b>Other Relevant USPSTF Recommendations</b>	The USPSTF has made recommendations on counseling and interventions to prevent tobacco use and tobacco-caused disease. These recommendations are available at <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a> .

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to [www.uspreventiveservicestaskforce.org](http://www.uspreventiveservicestaskforce.org).





# USPSTF LCS Guideline: 2013

## *Implications of USPSTF Grade B Recommendation*

- Grade “B” grade indicates either:
  - *high certainty that the net benefit is moderate or moderate certainty the net benefit is moderate to substantial, and that the particular service should be offered or provided*
- Patient Protection and Affordable Health Care Act (PPACA) requires private insurers to cover without a co-pay, all medical exams or procedures that receive a grade “B” or higher from the USPSTF
- Does not specify that Medicare provides full national coverage
- Fall 2013 CMS received 2 requests for a national coverage decision; finalized NCD February 2015



# USPSTF Process

## The Recommendation Development Process

The Task Force follows a multistep process when developing each of its recommendations. Use the graphic below to see where this recommendation is in the development process. [Learn about our full development process.](#)



## AHRQ Evidence Synthesis

<https://www.uspreventiveservicestaskforce.org/uspstf/document/draft-evidence-review/lung-cancer-screening1>

223 publications. 7 randomized controlled trials (RCTs) (described in 26 articles; 86,486 participants) evaluated lung cancer screening with LDCT; the National Lung Screening Trial (NLST) and Nederlands Leuvens Longkanker Screenings Onderzoek (NELSON) were the only adequately powered RCTs

# USPSTF Evidence Review: Conclusion

Screening high-risk persons with LDCT can reduce lung cancer mortality and may reduce all-cause mortality but also causes false-positive results leading to unnecessary tests and invasive procedures, overdiagnosis, incidental findings, short-term increases in distress (from indeterminate results), and, rarely, radiation-induced cancers.

The evidence for benefits comes from two RCTs that enrolled participants who were more likely to benefit than the U.S. screening-eligible population and that were mainly conducted at large academic centers, potentially limiting applicability to community-based practice. *(NNS to prevent 1 lung cancer death: NLST 323 over 6 yrs, NELSON 130 over 10 years)*

Application of lung cancer screening with current nodule management protocols (e.g., Lung-RADS) might improve the balance of benefits and harms *(Using Lung-RADS reduces false-positive results compared with the NLST criteria; using Lung-RADS would have prevented about 23 percent of all invasive procedures for false positives in the NLST)*

Use of risk prediction models might improve the balance of benefits and harms, although there remains considerable uncertainty about how such approaches would perform in actual practice because current evidence does not include prospective clinical utility studies.

# USPSTF LCS Guideline: 2020 Draft

<https://www.uspreventiveservicestaskforce.org/uspstf/draft-update-summary/lung-cancer-screening1>

## Recommendation Summary

Population	Recommendation	Grade
Adults ages 50 to 80 years who have a 20 pack-year smoking history, currently smoke, or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	<b>B</b>

# USPSTF LCS Guideline: 2020 Draft

## *Implications*

- The two changes nearly double the number of people eligible for lung cancer screening
- Many more African American & female smokers will be eligible – data show that:
  - African Americans and women tend to smoke fewer cigarettes than white men
  - African Americans have a higher risk of lung cancer than white people
- *“New evidence provides proof that there are real benefits to starting to screen at a younger age and among people with a lighter smoking history,”* says USPSTF member Michael Barry MD *“We can not only save more lives, we can also help people stay healthy longer.”*
- *“Some really good news from the changes to this recommendation is that it will mean more people are eligible for screening, including notably more African Americans and women,”* says USPSTF member John Wong MD *“Making screening for lung cancer available to people who have smoked less over time will help doctors support the health—and potentially save the lives—of more of their African American and female patients.”*

# Evaluation of USPSTF Lung Cancer Screening Guidelines Among African American Adult Smokers

Aldrich et al. JAMA Oncology 2019

- **Objective:** To evaluate the diagnostic accuracy of USPSTF lung cancer screening eligibility criteria in a predominantly African American and low-income cohort
- **Results:** Lowering the smoking pack-year eligibility criteria to a minimum 20-pack-year history was associated with an increased percentage of screening eligibility of African American smokers and with equitable performance of sensitivity and specificity compared with white smokers across all ages
- **Conclusions and relevance:** Current USPSTF lung cancer screening guidelines may be too conservative for African American smokers. The findings suggest that race-specific adjustment of pack-year criteria in lung cancer screening guidelines would result in more equitable screening for African American smokers at high risk for lung cancer.

Thank You

