National Comprehensive Cancer Network®

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Lung Cancer Screening

Version 1.2020 — May 14, 2019

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Þ Internal medicine	* Discussion section writing committee member
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NCCN Guidelines Panel Disclosures

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To find clinical trials online at NCCN Member Institutions, click here: nccn.org/clinical_trials/physician.html.

NCCN Categories of Evidence and Consensus: All recommendations are category 2A unless otherwise indicated.

See NCCN Categories of Evidence and Consensus.

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Updates in Version 1.2020 of the NCCN Guidelines for Lung Cancer Screening from Version 2.2019 include:

LCS-1

- **Risk Status**
  - **Group 1 age modified: Age range changed from 55–74 to 55–77 years (also applies to footnote h)**
- **Footnote g modified: Individuals exposed to second-hand smoke have a highly variable exposure to the carcinogens, with varying evidence for increased risk after this variable exposure. Therefore, second-hand smoke is not independently considered a risk factor *sufficient for recommending* ~~for~~ lung cancer screening.**

LCS-3

- **Change to CT recommendations: CT ± contrast changed to CT + contrast (also applies to LCS-4, LCS-7, LCS-8)**

LCS-8

- **Evaluation of Screening Findings modified**
  - **~~New or~~ Growing (>1.5 mm in solid component) *or new nodule***

LCS-A 2 of 2

- **Footnote 4 added: Reporting the presence or absence of coronary arterial calcification (CAC) detected on chest CT may be useful to the referring clinician and patient as a marker of atherosclerosis. CAC may be reported using either a visual score (none, mild, moderate, severe) or quantitative score (such as the Agatston score). Further evaluation is recommended if CAC is severe. Munden RF, Carter BW, Chiles C, et al. Managing incidental findings on thoracic CT: mediastinal and cardiovascular findings. A White Paper of the ACR Incidental Findings Committee. J Am Coll Radiol 2018;15:1087-1096; Hecht HS, Cronin P, Blaha MJ, et al. 2016 SCCT/STR guidelines for coronary artery calcium scoring of noncontrast noncardiac chest CT scans: a report of the Society of Cardiovascular Computed Tomography and Society of Thoracic Radiology. J Thorac Imaging 2017;32:W54-W66.**

LCS-B

- **References added: Ru Zhao Y, Xie X, de Koning HJ, et al. NELSON lung cancer screening study. Cancer Imaging 2011;11 Spec No A:S79-S84; De Koning H, Van Der Aalst C, Ten Haaf K, Oudkerk M. PL02.05: Effects of volume CT lung cancer screening: mortality results of the NELSON randomised controlled population based trial [abstract]. J Thorac Oncol 2018:13:S185; Pastorino U, Silva M, Sestini S, et al. Prolonged lung cancer screening reduced 10-year mortality in the MILD trial: new confirmation of lung cancer screening efficacy. Ann Oncol 2019; Published online April 1, 2019.**

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RISK ASSESSMENT[a,b]

- Smoking history[c]
- Radon exposure[d]
- Occupational exposure[e]
- Cancer history[f]
- Family history of lung cancer in first-degree relatives
- Disease history (COPD or pulmonary fibrosis)
- Smoking exposure[g] (second-hand smoke)
- Absence of symptoms or signs of lung cancer (if symptoms, see appropriate NCCN Guidelines)
- Functional status to support curative intent treatment
- Lung cancer survivors (see Surveillance in the NCCN Guidelines for Non-Small Cell Lung Cancer)

RISK STATUS

High risk:[h]

Group 1
- Age 55–77 y and
- ≥30 pack-year history of smoking and
- Smoking cessation <15 y

(category 1)

or

Group 2
- Age ≥50 y and
- ≥20 pack-year history of smoking and
- Additional risk factors (other than second-hand smoke) that increase the risk of lung cancer to ≥1.3% (see footnote i)

→ In candidates for screening, shared patient/physician decision-making is recommended, including a discussion of benefits/risks[j] → Low-dose CT (LDCT)[k] (category 1) → See Screening Findings (LCS-2)

Moderate risk:
- Age ≥50 y and
- ≥20 pack-year history of smoking or second-hand smoke exposure[g]
- No additional risk factors

→ Lung cancer screening not recommended

Low risk:
- Age <50 y and/or
- <20 pack-year history of smoking

→ Lung cancer screening not recommended

SCREENING

In candidates for screening, shared patient/physician decision-making is recommended, including a discussion of benefits/risks[i,j] → LDCT[k] → See Screening Findings (LCS-2)

[a] It is recommended that institutions performing lung cancer screening use a multidisciplinary approach that includes the specialties of thoracic radiology, pulmonary medicine, and thoracic surgery.
[b] Lung cancer screening is appropriate to consider for high-risk patients who are potential candidates for definitive treatment. Chest x-ray is not recommended for lung cancer screening.
[c] All current smokers should be advised to quit smoking, and former smokers should be advised to remain abstinent from smoking. For additional cessation support and resources, smokers can be referred to http://www.smokefree.gov. Lung cancer screening should not be considered a substitute for smoking cessation. Smoking history should document both extent of exposure in pack-years and the amount of time since smoking cessation in former smokers. See also the NCCN Guidelines for Smoking Cessation.
[d] Documented sustained and substantially elevated radon exposure.
[e] Agents that are identified specifically as carcinogens targeting the lungs: silica, cadmium, asbestos, arsenic, beryllium, chromium, diesel fumes, nickel, coal smoke, and soot.
[f] There is increased risk of developing new primary lung cancer among survivors of lung cancer, lymphomas, cancers of the head and neck, or smoking-related cancers.
[g] Individuals exposed to second-hand smoke have a highly variable exposure to the carcinogens, with varying evidence for increased risk after this variable exposure. Therefore, second-hand smoke is not independently considered a risk factor sufficient for recommending lung cancer screening.
[h] Although randomized trial evidence supports screening to age 77 years, there is uncertainty about the upper age limit to initiate or continue screening. One can consider screening beyond age 77 years as long as patient functional status and comorbidity allow consideration for curative intent therapy.
[i] The NCCN Panel recognizes there are individuals who would not have met the NLST criteria but are at similar risk to the NLST cohort and recommends lung cancer screening for these individuals. However, substantial uncertainty exists about the true benefits and harms of screening these individuals. It is reasonable to consider using the Tammemagi lung cancer risk calculator to assist in quantifying risk for individuals in this group, considering a 1.3% threshold of lung cancer risk over a 6-year timeframe was considered similar to that of the USPSTF (Tammemägi MC, Church TR, Hocking WG, et al. Evaluation of the lung cancer risks at which to screen ever- and never-smokers: screening rules applied to the PLCO and NLST cohorts. PLOS Med 2014;11:1-13).
[j] Shared decision-making aids may assist in determining if screening should be performed. Examples of decision-making aids: https://brocku.ca/lung-cancer-screening-and-risk-prediction/risk-calculators, http://www.shouldiscreen.com/benefits-and-harms-screening, and https://www.mskcc.org/cancer-care/types/lung/screening/lung-screening-decision-tool.
[k] All screening and follow-up chest CT scans should be performed at low dose (100–120 kVp and 40–60 mAs or less), unless evaluating mediastinal abnormalities or lymph nodes, where standard-dose CT with IV contrast might be appropriate (see LCS-A). There should be a systematic process for appropriate follow-up.

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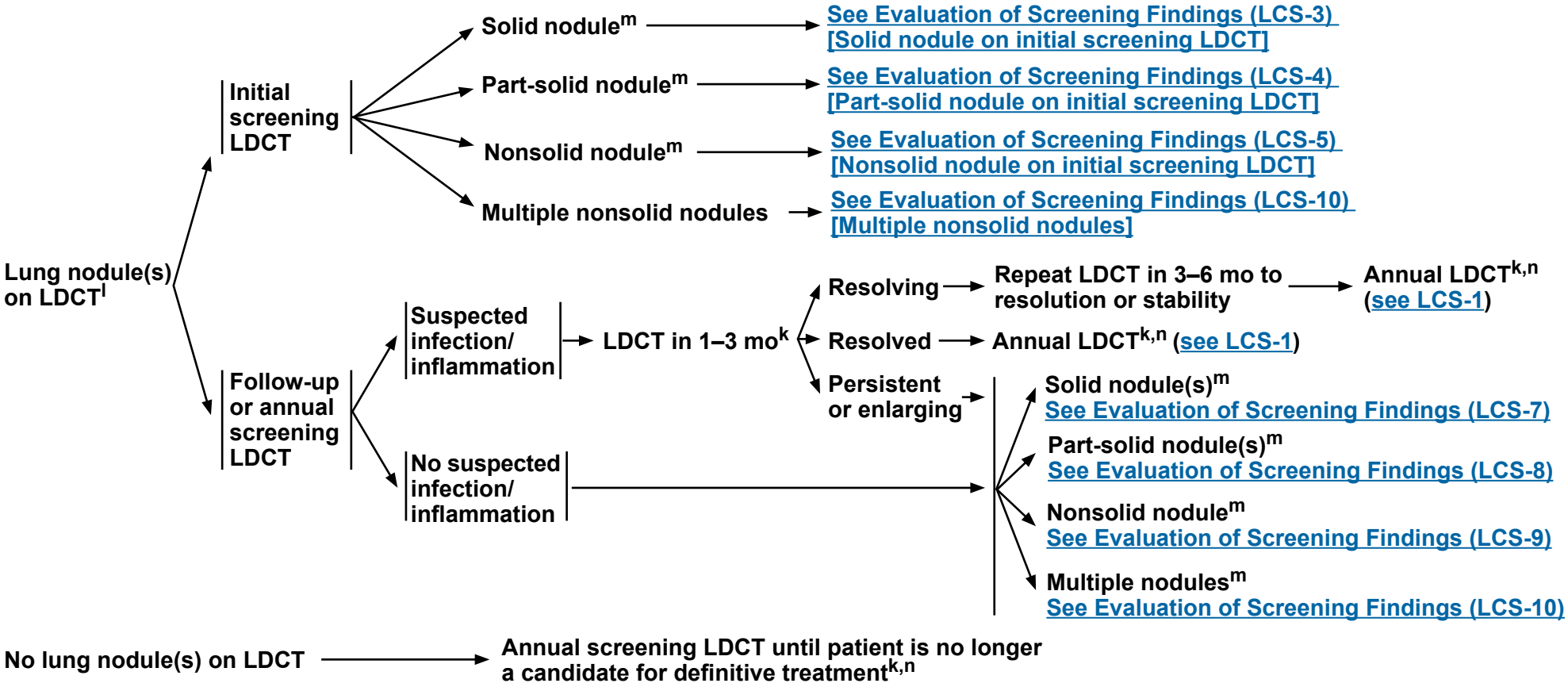
SCREENING FINDINGS



Findings requiring follow-up for diseases other than lung cancer (eg, suspicious for other cancers, COPD, moderate to severe coronary artery calcification, aortic aneurysm)

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[m]Without benign pattern of calcification, fat in nodule suggestive of hamartoma, or features suggesting inflammatory etiology. When multiple nodules or other findings are present that suggest occult infection or inflammation is a possibility, suggest follow-up LDCT in 1–3 months.

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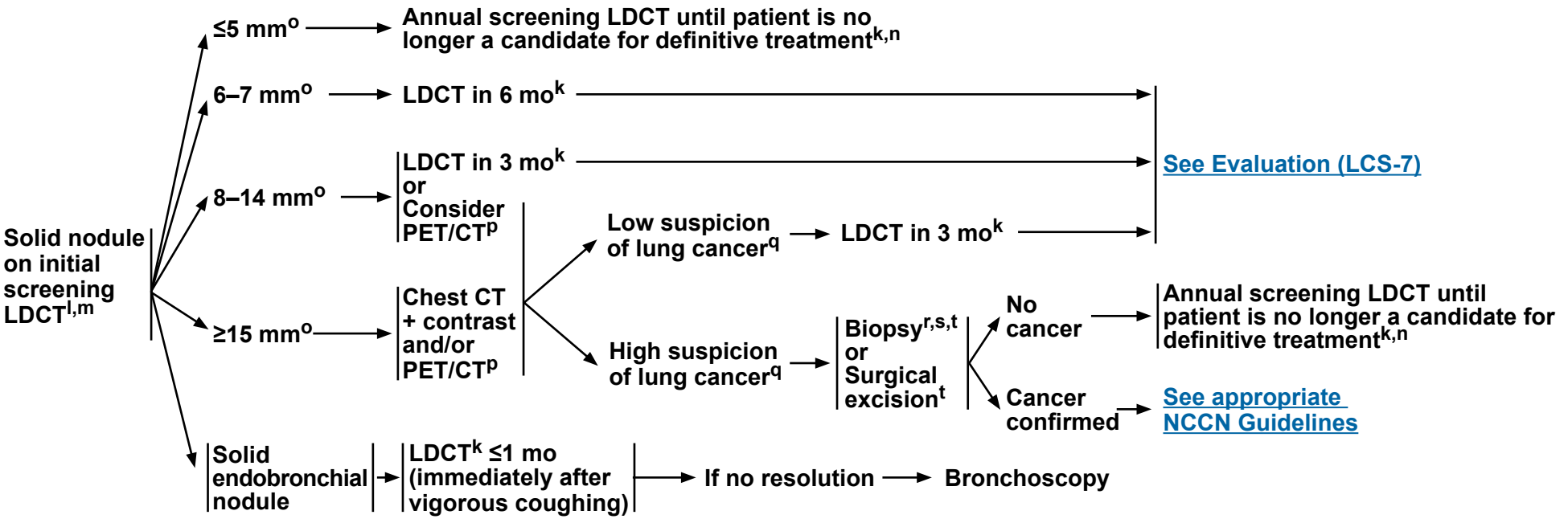

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[o]Nodules should be measured on lung windows and reported as the average diameter rounded to the nearest whole number; for round nodules only a single diameter measurement is necessary. Mean diameter is the mean of the longest diameter of the nodule and its perpendicular diameter.

[p]PET has a low sensitivity for nodules with less than 8 mm of solid component and for small nodules near the diaphragm. PET/CT is only one consideration of multiple criteria for determining whether a nodule has a high risk of being lung cancer. In areas endemic for fungal disease, the false-positive rate for PET/CT is higher.

[q]The evaluation for the suspicion of lung cancer requires a multidisciplinary approach with expertise in lung nodule management (thoracic radiology, pulmonary medicine, and thoracic surgery). This may include use of a lung nodule risk calculator to assist with probability determination. Examples of lung nodule risk calculators: Mayo risk model; Brock university model; model by Herder, GJ et al. Chest 2005;128:2490-2496. The use of risk calculators does not replace multidisciplinary nodule management. Geographic and other factors can substantially influence the accuracy of nodule calculators.

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[s]If biopsy is non-diagnostic and a strong suspicion for cancer persists, suggest repeat biopsy or surgical excision or short-interval follow-up (3 months).

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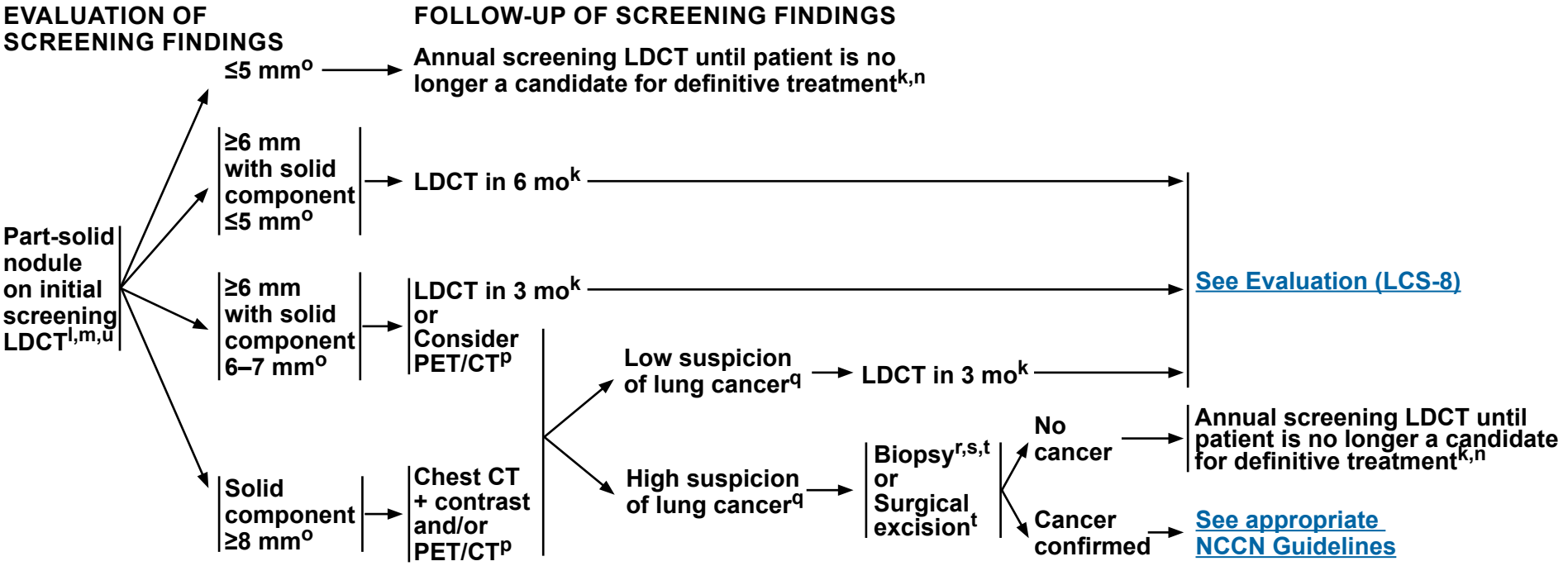

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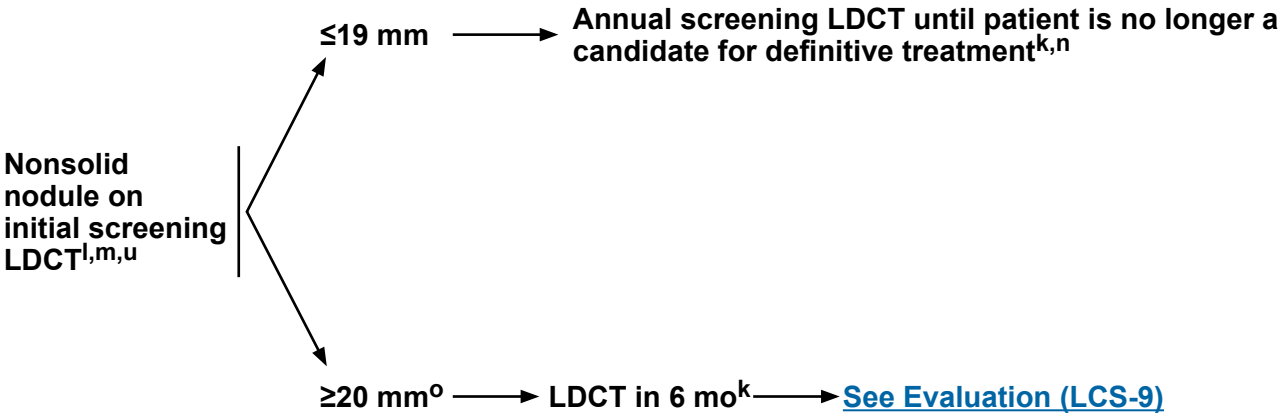

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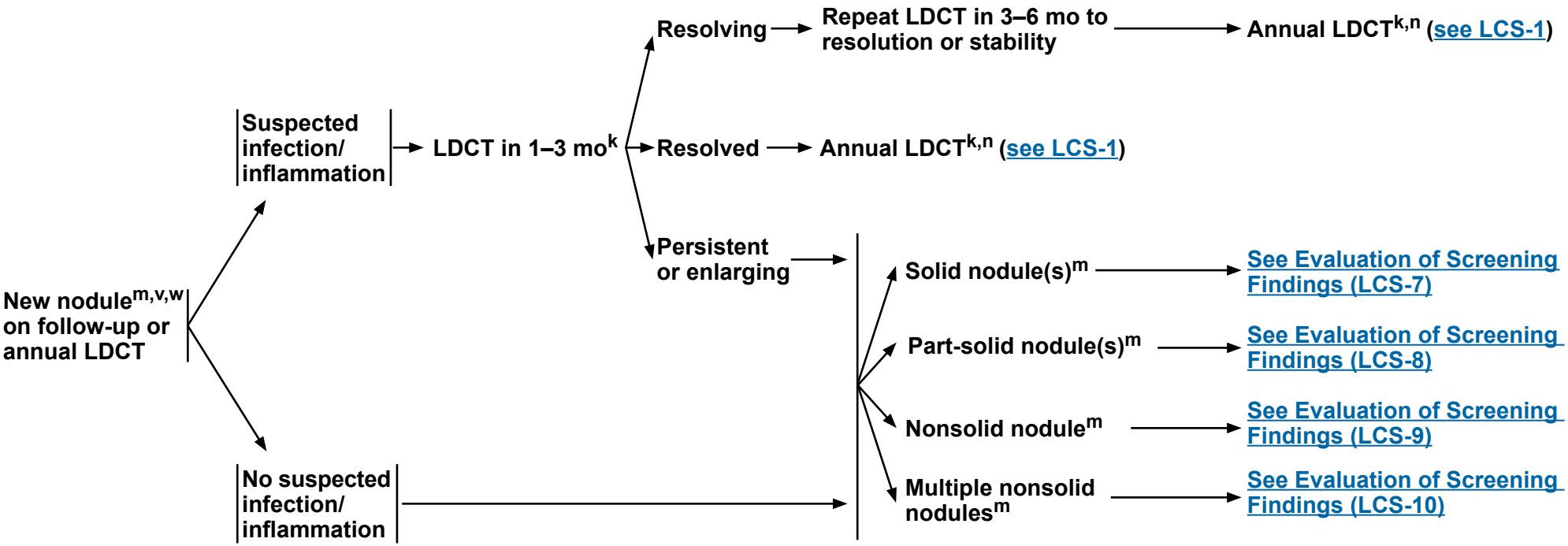

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[v]Rapid increase in size should raise suspicion of inflammatory etiology or malignancy other than non-small cell lung cancer.
[w]New nodule is defined as ≥3 mm in mean diameter.

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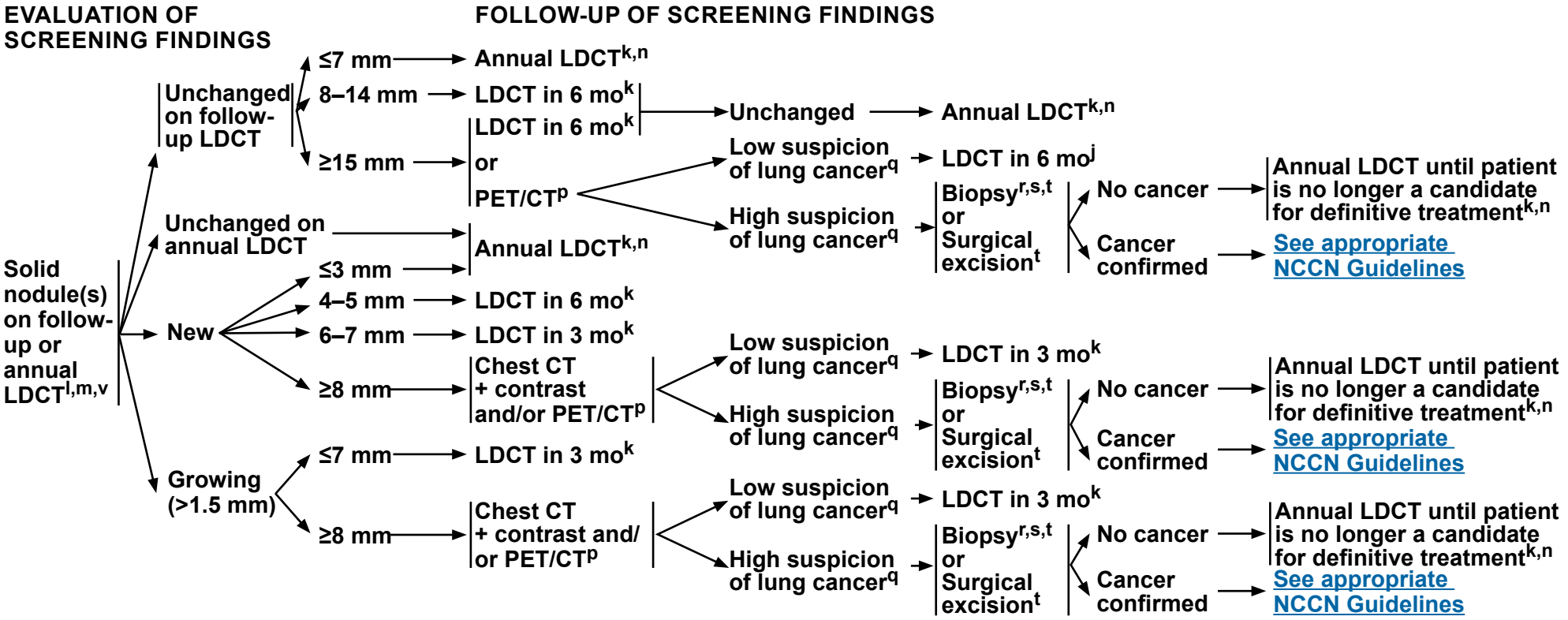

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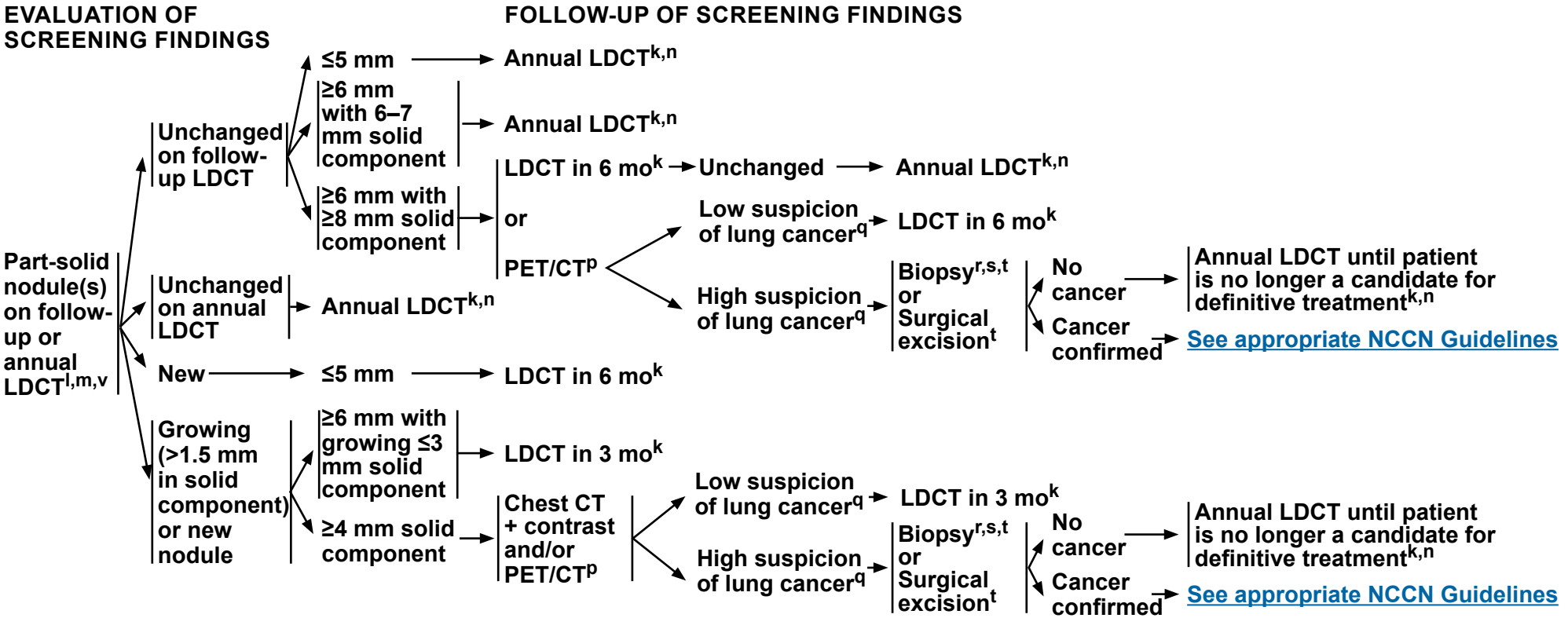

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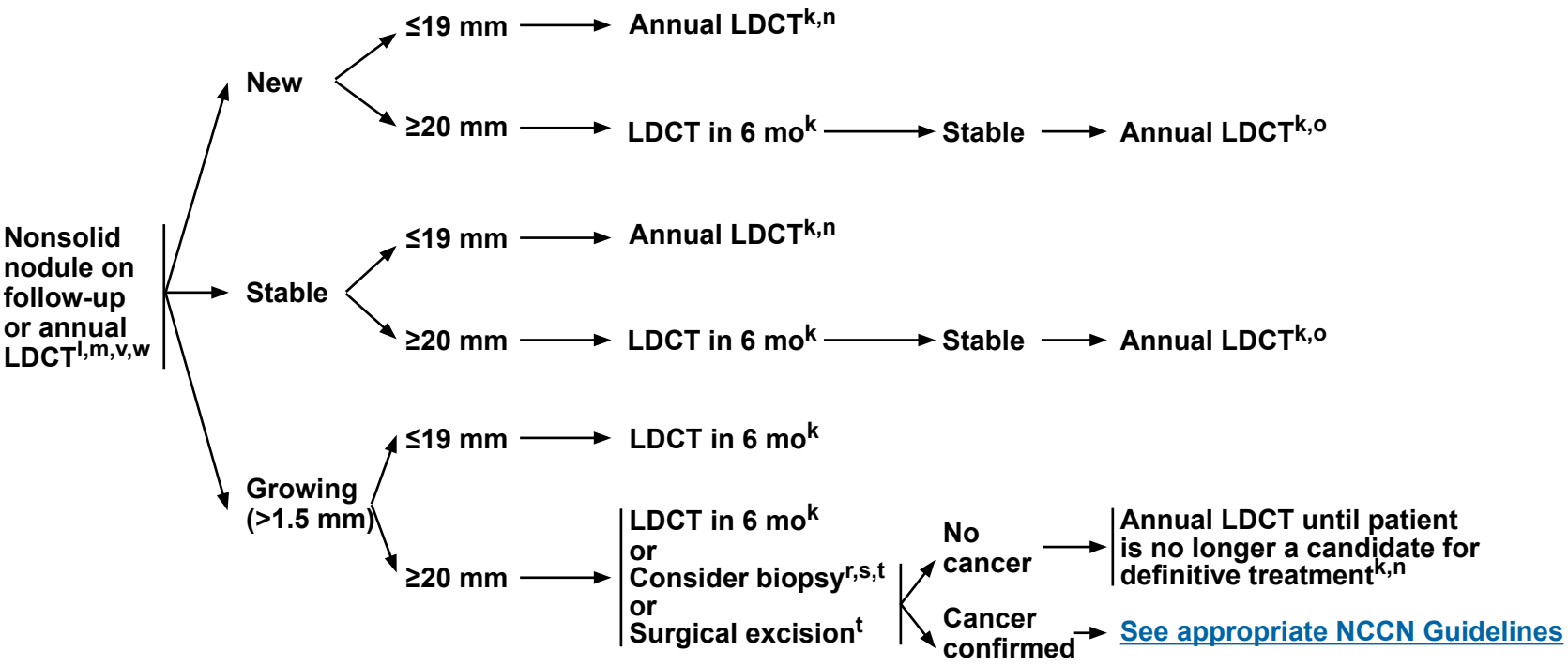
FOLLOW-UP OF SCREENING FINDINGS

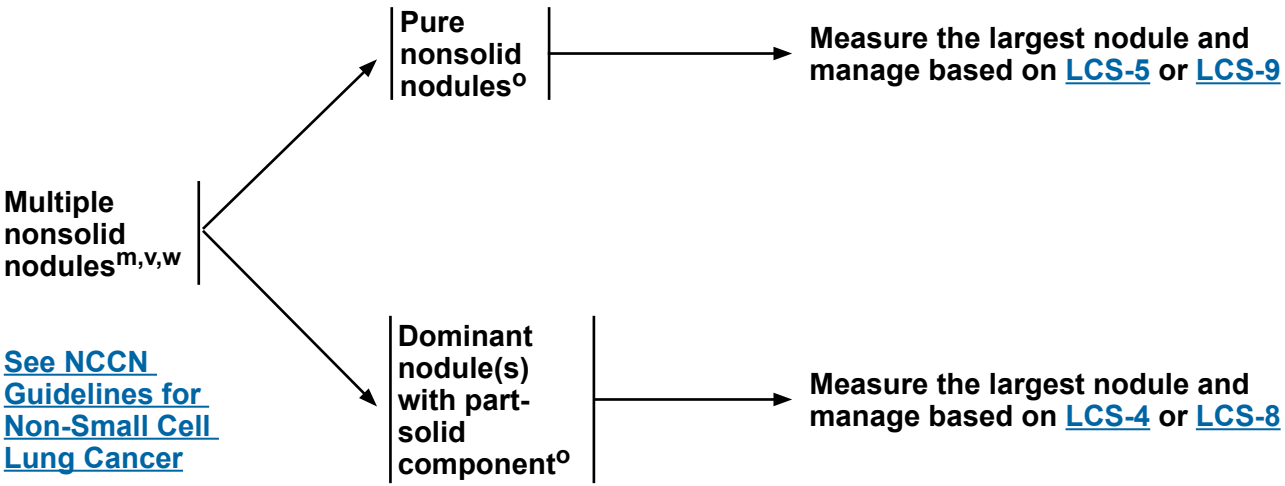


[k]All screening and follow-up chest CT scans should be performed at low dose (100–120 kVp and 40–60 mAs or less), unless evaluating mediastinal abnormalities or lymph nodes, where standard-dose CT with IV contrast might be appropriate (see LCS-A). There should be a systematic process for appropriate follow-up.
[l]The NCCN Guidelines for Lung Cancer Screening are harmonized with Lung-RADS (http://www.acr.org/Quality-Safety/Resources/LungRADS). Pinsky PF, Gierada DS, Black W, et al. Performance of Lung-RADS in the National Lung Screening Trial: a retrospective assessment. Ann Intern Med 2015;162:485-491.
[m]Without benign pattern of calcification, fat in nodule suggestive of hamartoma, or features suggesting inflammatory etiology. When multiple nodules or other findings are present that suggest occult infection or inflammation is a possibility, suggest follow-up LDCT in 1–3 months.
[n]There is uncertainty about the appropriate duration of screening and the age at which screening is no longer appropriate.
[r]Tissue samples need to be adequate for both histology and molecular testing. Travis WD, et al. Rationale for classification in small biopsies and cytology. In, WHO Classification of Tumours of the Lung, Pleura, Thymus and Heart, 4th Ed. Lyon:International Agency for Research on Cancer;2015:16-17.
[s]If biopsy is non-diagnostic and a strong suspicion for cancer persists, suggest repeat biopsy or surgical excision or short-interval follow-up (3 months).
[t]See the diagnostic evaluation of a lung nodule (DIAG-1 through DIAG-A) in the NCCN Guidelines for Non-Small Cell Lung Cancer.
[u]It is crucial that all nonsolid lesions be reviewed at thin (<1.5 mm) slices to exclude any solid components. Any solid component in the nodule requires management of the lesion with the part-solid recommendations (see LCS-4 or LCS-8).
[v]Rapid increase in size should raise suspicion of inflammatory etiology or malignancy other than non-small cell lung cancer (see LCS-6).

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

EVALUATION OF SCREENING FINDINGS

FOLLOW-UP OF SCREENING FINDINGS



[m]Without benign pattern of calcification, fat in nodule suggestive of hamartoma, or features suggesting inflammatory etiology. When multiple nodules or other findings are present that suggest occult infection or inflammation is a possibility, suggest follow-up LDCT in 1–3 months.
[o]Nodules should be measured on lung windows and reported as the average diameter rounded to the nearest whole number; for round nodules only a single diameter measurement is necessary. Mean diameter is the mean of the longest diameter of the nodule and its perpendicular diameter.
[u]It is crucial that all nonsolid lesions be reviewed at thin (<1.5 mm) slices to exclude any solid components. Any solid component in the nodule requires management of the lesion with the part-solid recommendations (see LCS-4 or LCS-8).
[v]Rapid increase in size should raise suspicion of inflammatory etiology or malignancy other than non-small cell lung cancer (see LCS-6).

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LOW-DOSE COMPUTED TOMOGRAPHY ACQUISITION, STORAGE, INTERPRETATION, AND NODULE REPORTING (Lung-RADS)[1-4]

Acquisition	Small Patient (BMI ≤30)	Large Patient (BMI >30)
Total radiation exposure	≤3 mSv	≤5 mSv
kVp	100–120	120
mAs	≤40	≤60
	All Patients	
Gantry rotation speed	≤0.5	
Detector collimation	≤1.5 mm	
Slice width	≤2.5 mm; ≤1.0 mm preferred	
Slice interval	≤slice width; 50% overlap preferred for 3D and CAD applications	
Scan acquisition time	≤10 seconds (single breath hold)	
Breathing	Maximum inspiration	
Contrast	No oral or intravenous contrast	
CT scanner detectors	≥16	
Storage	All acquired images, including thin sections; MIPs and CAD renderings if used	
Interpretation Tools		
Platform	Computer workstation review	
Image type	Standard and MIP images	
Comparison studies	Comparison with prior chest CT images (not reports) is essential to evaluate change in size, morphology, and density of nodules; review of serial chest CT exams is important to detect slow growth	
Nodule Parameters		
Size	Largest mean diameter on a single image (mean of the longest diameter of the nodule and its perpendicular diameter, when compared to the baseline scan)	
Density	Solid, ground-glass, or mixed (mixed; otherwise referred to as part solid)	
Calcification	Present/absent; if present: solid, central vs. eccentric, concentric rings, popcorn, stippled, amorphous	
Fat	Report if present	
Shape/Margin	Round/ovoid, triangular/smooth, lobulated, spiculated	
Lung location	By lobe of the lung, preferably by segment, and if subpleural	
Location in dataset	Specify series and image number for future comparison	
Temporal comparison	If unchanged, include the longest duration of no change as directly viewed by the interpreter on the images (not by report); if changed, report current and prior size	

See Footnotes and References LCS-A 2 of 2

Note: All recommendations are category 2A unless otherwise indicated.
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Footnotes and References

[1]Protocol information: http://www.aapm.org/pubs/CTProtocols/documents/LungCancerScreeningCT.pdf

[2]The LDCT acquisition parameters should be used both for annual screening LDCT exams and for interim LDCTs recommended to evaluate positive screens. The former are considered screening CTs by CPT code, and the latter are considered diagnostic CTs by CPT code.

[3]Pinsky PF, Gierada DS, Black W, et al. Performance of Lung-RADS in the National Lung Screening Trial: a retrospective assessment. Ann Intern Med 2015;162:485-491.

[4]Reporting the presence or absence of coronary arterial calcification (CAC) detected on chest CT may be useful to the referring clinician and patient as a marker of atherosclerosis. CAC may be reported using either a visual score (none, mild, moderate, severe) or quantitative score (such as the Agatston score). Further evaluation is recommended if CAC is severe. Munden RF, Carter BW, Chiles C, et al. Managing incidental findings on thoracic CT: mediastinal and cardiovascular findings. A White Paper of the ACR Incidental Findings Committee. J Am Coll Radiol 2018;15:1087-1096; Hecht HS, Cronin P, Blaha MJ, et al. 2016 SCCT/STR guidelines for coronary artery calcium scoring of noncontrast noncardiac chest CT scans: a report of the Society of Cardiovascular Computed Tomography and Society of Thoracic Radiology. J Thorac Imaging 2017;32:W54-W66.

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RISKS/BENEFITS OF LUNG CANCER SCREENING*

RISKS
- Futile detection of small aggressive tumors or indolent disease
- Quality of life
  - Anxiety of test findings
- Physical complications from diagnostic workup
- False-positive results
- False-negative results
- Unnecessary testing and procedures
- Radiation exposure
- Cost
- Incidental lesions

BENEFITS
- Decreased lung cancer mortality[1-3]
- Quality of life
  - Reduction in disease-related morbidity
  - Reduction in treatment-related morbidity
  - Improvement in healthy lifestyles
  - Reduction in anxiety/psychosocial burden
- Discovery of other significant occult health risks (eg, thyroid nodule, severe but silent coronary artery disease, early renal cancer in upper pole of kidney, aortic aneurysm, breast cancer)

*See Discussion for more detailed information.

[1]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.
[2]Ru Zhao Y, Xie X, de Koning HJ, et al. NELSON lung cancer screening study. Cancer Imaging 2011;11 Spec No A:S79-8S4.
[3]De Koning H, Van Der Aalst C, Ten Haaf K, Oudkerk M. PL02.05: Effects of volume CT lung cancer screening: Mortality results of the NELSON randomised-controlled population based trial [abstract]. J Thorac Oncol 2018:13:S185; Pastorino U, Silva M, Sestini S, et al. Prolonged lung cancer screening reduced 10-year mortality in the MILD trial: new confirmation of lung cancer screening efficacy. Ann Oncol 2019; Published online April 1, 2019.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any patient with cancer is in a clinical trial. Participation in clinical trials is especially encouraged.

NCCN Categories of Evidence and Consensus	
Category 1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

All recommendations are category 2A unless otherwise indicated.

Discussion

Table of Contents

Overview

Lung cancer is the leading cause of cancer-related mortality in the United States and worldwide.[1-5] In 2019, it is estimated that 142,670 deaths (76,650 in men and 66,020 in women) from lung cancer will occur in the United States, which is about 24% of all the U.S. deaths from cancer.[6,7] Five-year survival rates for lung cancer are only 19%, partly because most patients have advanced-stage lung cancer at initial diagnosis.[7] These facts—combined with the success of screening in improving outcomes in patients with cervical, colon, and breast cancers—have been the impetus for studies to develop an effective lung cancer screening test.[8-10] Ideally, effective screening will lead to earlier detection of lung cancer (before patients have symptoms and when treatment is more likely to be effective) and will decrease mortality.[11] Currently, most lung cancer is diagnosed clinically when patients present with symptoms such as persistent cough, pain, and weight loss; unfortunately, patients with these symptoms usually have advanced lung cancer. Early detection of lung cancer is an important opportunity for decreasing mortality. Data support using low-dose CT (LDCT) of the chest to screen select patients who are at high risk for lung cancer.[11-15] Chest x-ray is not recommended for lung cancer screening.[11,16,17]

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Lung Cancer Screening were developed in 2011 and have been subsequently updated at least once every year.[11,18,19] These NCCN Guidelines®: 1) describe risk factors for lung cancer; 2) recommend criteria for selecting individuals with high-risk factors for screening; 3) provide recommendations for evaluation and follow-up of lung nodules found during initial and subsequent screening; 4) discuss the accuracy of chest LDCT screening protocols and imaging modalities; and 5) discuss the benefits and risks of LDCT screening. The *Summary of the Guidelines Updates* section in the algorithm briefly describes the new changes for the 2020 update, which are described in greater detail in this revised Discussion text; recent references have been added. For example, the upper limit of the age cutoff for lung screening has been revised to 77 years (from 74 years) when assessing whether patients are at high risk for lung cancer.

Adenocarcinoma is the most common type of non-small cell lung cancer (NSCLC).[7,20] Thus, these NCCN Guidelines for Lung Cancer Screening mainly refer to detection of adenocarcinoma. Other types of cancer can metastasize to the lungs, such as breast cancer. There are also less common cancers of the lung or chest, such as small cell lung cancer, malignant pleural mesothelioma, thymomas, and thymic carcinoma. Lung screening may also detect noncancerous conditions of the thorax (eg, aortic aneurysm, coronary artery calcification [CAC]), tumors or benign disease outside of the chest (eg, renal cell carcinoma, adrenal adenoma), and infections (eg, tuberculosis, sarcoidosis).[21-23]

The goal of screening is to detect disease at a stage when it is not causing symptoms and when treatment will be most successful. Screening should benefit the individual by increasing life expectancy and increasing quality of life. The rate of false-positive results should be low to prevent unnecessary additional testing. The large fraction of the population without the disease should not be harmed (low risk), and the screening test should not be so expensive that it places an onerous burden on the health care system. Thus, the screening test should: 1) improve outcomes; 2) be scientifically validated (eg, have acceptable levels of sensitivity and specificity); and 3) be low risk, reproducible, accessible, and cost-effective.

Perhaps the most difficult aspect of lung cancer screening is addressing the moral obligation. As part of the Hippocratic oath, physicians promise to first *do no harm*.[24] The dilemma is that if lung cancer screening is beneficial but physicians do not use it, they are denying patients effective care. If lung cancer screening is not effective, then patients may be

harmed from overdiagnosis, increased testing, invasive testing or procedures, and the anxiety of a potential cancer diagnosis.[25-28]

Literature Search Criteria and Guidelines Update Methodology

An electronic search of the PubMed database was performed to obtain key literature in lung cancer screening using the following search terms: lung cancer screening computed tomography, low-dose computed tomography, and low-dose CT screening. The PubMed database was chosen, because it is the most widely used resource for medical literature and indexes peer-reviewed biomedical literature. The search results were narrowed by selecting studies in humans published in English. Results were confined to the following article types: Clinical Trial, Phase 2; Clinical Trial, Phase 3; Clinical Trial, Phase 4; Guideline; Meta-Analysis; Randomized Controlled Trial; Systematic Reviews; and Validation Studies.

The data from key PubMed articles selected by the NCCN Lung Cancer Screening Panel for review during the NCCN Guidelines update meeting, as well as articles from additional sources deemed as relevant to these Guidelines and discussed by the NCCN Lung Cancer Screening Panel, have been included in this version of the Discussion section (eg, e-publications ahead of print, meeting abstracts). If high-level evidence is lacking, recommendations are based on the NCCN Lung Cancer Screening Panel's review of lower-level evidence and expert opinion. The complete details of the development and update of the NCCN Guidelines are available at www.NCCN.org.

LDCT as Part of a Lung Screening Program

Lung cancer screening with LDCT should be part of a program of care and should not be performed in isolation as a free-standing test.[29-32] Trained personnel and an organized administrative system to contact patients to achieve compliance with recommended follow-up studies are required for an effective lung screening program.[31,33,34] The NCCN-recommended follow-up intervals assume compliance with follow-up recommendations. To help ensure good image quality, all chest LDCT screening programs should use CT scanners that meet the standards of the American College of Radiology (ACR).[35] The ACR has developed Lung Imaging Reporting and Data System (Lung-RADS) to standardize the reporting and management of LDCT lung examinations.[29,36-38] The Lung-RADS protocol has been shown to improve the detection of lung cancer and to decrease the false-positive rate.[31,33,37-42] When assessing subsequent scans, the most important radiologic factors are resolution, stability, or growth of previous nodules or appearance of a new nodule(s) when compared with a previous imaging study.

Given the high percentage of false-positive results and the downstream management that ensues for many patients, the risks and benefits of lung cancer screening should be discussed with the individual before an initial screening LDCT scan is performed.[26,27,43,44] Shared patient/physician decision-making may be the best approach before deciding whether to do LDCT lung screening, especially for patients with comorbid conditions.[16,45,46] It is recommended that institutions performing lung cancer screening use a multidisciplinary approach that may include specialties such as chest radiology, pulmonary medicine, and thoracic surgery.[47] Guidelines from the American College of Chest Physicians (ACCP) and ASCO state that only centers with considerable expertise in lung cancer screening should perform an LDCT.[48]

Randomized Trials

Disease-specific mortality, which is the number of cancer deaths relative to the number of individuals screened, is considered the ultimate test of screening effectiveness and is the only test that is without bias.[49] Randomized controlled screening trials are essential for determining whether cancer screening decreases disease-specific mortality.

Nonrandomized trials are subject to biases that may cause an apparent increase in survival (eg, lead-time bias, length-time bias).[50]

If lung cancer is detected through screening before symptoms occur, then the lead time in diagnosis equals the length of time between screening detection and when the diagnosis otherwise would have occurred, either as a result of symptoms or other imaging. Even if early treatment had no benefit, the survival of the screened person is increased simply by the addition of the lead time. Length-time bias refers to the tendency of the screening test to detect cancers that take longer to become symptomatic, possibly because they are slower-growing and perhaps are indolent cancers. Survival (the number of individuals who are alive after detection and treatment of disease relative to the number of individuals diagnosed with the disease) has often been reported but is subject to these biases.[10] For further discussion of randomized and nonrandomized screening trials, see *Benefits of Lung Cancer Screening* in this Discussion.

Several randomized trials have assessed whether screening with chest radiography could improve lung cancer survival. Many of these studies were flawed in their design or power, and all were negative.[27,51-54] A phase 3 randomized trial (The Prostate, Lung, Colorectal, and Ovarian [PLCO]) reported that annual screening with chest radiography is not useful for lung cancer screening in individuals at low risk for lung cancer.[55] Other studies have focused on the more sensitive modality of LDCT-based lung cancer screening (see *Benefits of Lung Cancer Screening* in this Discussion). Analyses of some lung cancer screening studies using LDCT scans suggest that overdiagnosis (ie, diagnosis of cancer that would never be life-threatening) and false-positive screening tests are significant concerns.[28,56,57] Although LDCT scanning may be a better screening test for lung cancer, it also has limitations (see *Benefits of Lung Cancer Screening* and *Risks of Lung Cancer Screening* in this Discussion).[27]

Multiple randomized trials have assessed LDCT screening for lung cancer among high-risk groups, including: 1) the National Lung Screening Trial (NLST), sponsored by the NCI;[10] 2) the Dutch-Belgian randomized lung cancer screening trial (NELSON); 3) the UK Lung Screen (UKLS); 4) the Danish Lung Cancer Screening Trial (DLCST); and 5) Detection And screening of early lung cancer with Novel imaging Technology (DANTE) trial.[12,58-74] The published results from the NLST show that LDCT decreased the relative risk (RR) of death from lung cancer by 20% (95% CI, 6.8–26.7; P = .004) when compared with chest radiography alone.[11] Preliminary data from the NELSON trial suggest that LDCT decreases lung cancer mortality in both men and women at high risk for lung cancer compared with no screening, with a substantially higher benefit seen for women.[58] Although the NLST also reported a significant decrease in all-cause mortality of 7%, the apparent decrease is not significant after lung cancer mortality has been subtracted. Several smaller trials have reported that screening with LDCT did not decrease mortality; however, the DLCST trial included lower risk individuals compared with the NLST.[64,75]

The Veterans Health Administration (VHA) did a demonstration project of lung cancer screening in veterans at high risk for lung cancer in the United States to assess the feasibility of screening the large veterans population (6.7 million veterans).[76] About 58% of high-risk candidates agreed to screening. Of 2106 veterans who had screening, nodules were found in 1257 (59.7%), and lung cancer was found in 31 (1.5%) veterans. Importantly, of the 73 patients with findings considered suspicious for lung cancer, 31 (42%) were subsequently diagnosed with cancer. Incidental findings were noted in 857 (40.7%) veterans (eg, emphysema, other pulmonary abnormalities, CAC). When compared with candidates in the NLST, veterans were older (≥65 years; NLST: 26.6% vs. VHA: 52.5%), more likely to be men (NLST: 59% vs. VHA: 96.3%), and more likely to be current smokers (NLST: 48.2% vs. VHA: 56.6%). Veterans also had a

heavier smoking history compared with those in the NLST. It is estimated that about 900,000 veterans will be eligible for lung cancer screening. The high rate of false positives (58.2%) in the VHA project has lead to suggestions that screening should not be implemented in the VHA population. However, the VHA study did not use modern Lung-RADS nodule reporting or management, leading to an over-read of positive findings in 860 (41%) of the 1293 nodules found. If current criteria for nodule management had been used in the VHA study, then positive findings would have been reported in 423 of the 2106 patients, or 20%. Further, an analysis suggests that the benefits of lung cancer screening will outweigh the potential harms if additional risk stratification is done and newer nodule management guidelines are used.[37,77] False-positive reporting overestimates the risk of unintended harm because only a percentage of positive findings are considered for invasive tissue diagnosis.[39]

Lung Cancer Screening Guidelines

NCCN was the first major organization to develop lung cancer screening guidelines using LDCT based on the NLST data.[18] The International Association for the Study of Lung Cancer (IASLC) supports the NCCN Guidelines by emphasizing the need for guidelines, a multidisciplinary team approach, and integrated smoking cessation programs.[47] The U.S. Preventive Services Task Force (USPSTF) recommends lung screening with LDCT; their B recommendation means that lung screening is covered under the Affordable Care Act for individuals with high-risk factors who are 55 to 80 years of age.[16] The Centers for Medicare & Medicaid Services (CMS) covers annual screening LDCT for appropriate Medicare beneficiaries at high risk for lung cancer (ie, smokers and former smokers aged 55–77 years with a 30 pack-year cigarette smoking history) if they also receive counseling and participate in shared decision-making before screening. ACCP and ASCO also recommend lung cancer screening with LDCT for individuals at high risk if they meet the criteria of the NLST (ie, smokers and former smokers aged 55–74 years with a 30 pack-year smoking history);[48] this recommendation has also been approved by the American Thoracic Society. The American Cancer Society, American Association for Thoracic Surgery, and USPSTF have also developed guidelines for lung cancer screening with LDCT.[16,78-80]

Risk Factors for Lung Cancer

An essential goal of any lung cancer screening protocol is to identify the populations that are at a high risk for developing the disease. Although smoking tobacco is a well-established risk factor for lung cancer, other environmental and genetic factors also seem to increase risk.[38,81-84] This section reviews the currently known risk factors for the development of lung cancer to identify populations with high-risk factors that should be targeted for screening. Note that individuals with high-risk factors who are candidates for screening should not have any symptoms suggestive of lung cancer (eg, cough, pain, weight loss).

Tobacco Smoke

Active Tobacco Use

Tobacco smoking is a major modifiable risk factor in the development of lung cancer and accounts for 85% of all lung cancer-related deaths.[3,8,9] Approximately 34.3 million U.S. adults currently smoke cigarettes.[85-87] Smoking tobacco is also associated with other cancers and diseases, such as head and neck, kidney, bladder, pancreatic, gastric, or cervical cancer or acute myeloid leukemia.[3] It is estimated that about 480,000 U.S. adults die from smoking-related illnesses each year; cigarette smoking is estimated to cause about 30% of deaths due to cancer.[86,88,89] Globally, it is estimated that deaths from smoking tobacco will increase to 10 million by 2020.[90] The causal relationship between tobacco smoking and lung cancer was reported in 1950.[91,92] Since then, the risk of developing lung cancer from smoking tobacco has been firmly established.[3] Tobacco smoke contains more than 7000 compounds, and at least 69 of these are known

carcinogens that increase the risk of cancerous mutations at the cellular level, especially among individuals with a genetic predisposition.[93-97] The FDA has defined a list of 93 chemicals that are considered harmful and potentially harmful constituents (HPHCs) in tobacco products or tobacco smoke.

A dose-response relationship exists between smoking tobacco and the risk of developing lung cancer; however, there is no risk-free level of tobacco exposure. The RR for lung cancer is approximately 20-fold higher[3,98] for smokers than for nonsmokers. Cessation of tobacco smoking decreases the risk for lung cancer.[94,99-102] But, even former smokers have a higher risk for lung cancer compared with never-smokers. As a result, current or past history of tobacco smoking is considered a risk factor for the development of lung cancer, irrespective of the magnitude of exposure and the time since smoking cessation.

In the NCCN Guidelines, individuals aged 55 to 77 years with a 30 or more pack-year history of smoking tobacco are selected as the highest-risk group for lung cancer and are recommended for LDCT screening (category 1) based on criteria for entry into the NLST (see *Risk Status* in the algorithm).[10,11] Individuals with a 30 pack-year smoking history who quit smoking less than 15 years ago are still in this highest-risk group. *Pack-years* of smoking history is defined as the number of packs of cigarettes smoked every day multiplied by the number of years of smoking. Note that data for determining whether patients are at high risk for cancer are based on cigarette smoking and not on other kinds of tobacco products, which may also put patients at risk for cancer.[85,103,104] For those who smoke cigars, information is available that may be useful for determining the risk for cancer.[105,106]

Exposure to Second-Hand Smoke

The relationship between lung cancer and exposure to second-hand smoke (also known as environmental tobacco smoke, passive smoke, and involuntary smoke [ie, smoke created by others who are smoking]) was first suggested in epidemiologic studies published in 1981.[107] Since then, several studies and pooled RR estimates have suggested that second-hand smoke causally increases the risk for lung cancer among nonsmokers.[108] The NCCN Lung Cancer Screening Panel does not feel that second-hand smoke is an independent risk factor sufficient for recommending screening, because the association is either weak or variable (see the algorithm). Second-hand smoke does not confer a great enough risk for exposed individuals to be candidates for lung cancer screening in the NCCN Guidelines.

A pooled analysis of 37 published studies found an estimated RR of 1.24 (95% CI, 1.13–1.36) for adult nonsmokers who live with a smoker.[109] A pooled estimate from 25 studies found an RR of 1.22 (95% CI, 1.13–1.33) for lung cancer risk from exposure to second-hand smoke at the workplace.[108] The pooled estimate for 6 studies suggests a dose–response relationship between number of years of second-hand smoke exposure and lung cancer risk.[108] The data are inconsistent for second-hand smoke exposure during childhood and subsequent lung cancer risk in adulthood. For childhood tobacco smoke exposure, pooled RR estimates for the development of lung cancer were 0.93 (95% CI, 0.81–1.07) for studies conducted in the United States, 0.81 (95% CI, 0.71–0.92) for studies conducted in European countries, and 1.59 (95% CI, 1.18–2.15) for studies conducted in Asian countries.[108]

Occupational Exposure to Carcinogens

Approximately 150 agents are classified as known or probable human carcinogens (IARC 2002). Agents that are identified specifically as carcinogens targeting the lungs include arsenic, chromium, asbestos, nickel, cadmium, beryllium, silica, diesel fumes, coal smoke, and soot.[82,110-116] The calculated mean RR for development of lung cancer is 1.59 for individuals in the United States who have a known occupational

exposure to these agents.[82,116] Among those who are exposed to these carcinogens, data suggest that smokers have a greater risk for lung cancer than nonsmokers.[111,113,117-119]

Residential Radon Exposure

Radon (a gaseous decay product of uranium-238 and radium-226) has been implicated in the development of lung cancer.[120] The risk for lung cancer from occupational exposure among uranium miners is well established.[121,122] The risk associated with residential radon is uncertain. A meta-analysis in 1997 of 8 studies yielded an estimated RR of 1.14 (95% CI, 1.0–1.3).[123] A 2005 meta-analysis of 13 studies (using individual data from patients) reported a linear relationship between the amount of radon detected in a home and the risk of developing lung cancer.[124] Among those exposed to radon, smokers have a greater risk for lung cancer than nonsmokers.[124] The NCCN Lung Cancer Screening Panel feels that radon is a risk factor if there is a documented sustained and substantially elevated radon exposure.

History of Cancer

Evidence shows an increased risk for new primary lung cancers among patients who survive lung cancer, lymphomas, or smoking-related cancers, such as bladder cancer or head and neck cancer.[125] Patients who survive small cell lung cancer have a 3.5-fold increase in the risk for developing a new primary cancer, predominantly NSCLC.[126] Risk for second lung cancers is increased if survivors continue smoking.[127]

The risk for subsequent lung cancers is increased in patients who have been previously treated with either chest irradiation or alkylating agents. Patients previously treated with chest irradiation have a 13-fold increase in risk for developing new primary lung cancer, and those previously treated with alkylating agents have an estimated RR of 9.4. In patients previously treated for Hodgkin's lymphoma, the RR for new primary lung cancer is 4.2 if previously treated with alkylating agents, and 5.9 if previously treated with 5 Gy or more of radiation therapy.[128]

In patients with head and neck cancers, subsequent new primary lung cancer may occur synchronously or metachronously. New primary tumors are seen in approximately 9% of patients.[129] Most of these tend to be squamous cell cancers and a third of them occur in the lung. In patients with laryngeal or hypopharyngeal cancer, the lung is the most common site of second primary cancers.[130] Evidence suggests that patients who are successfully treated (ie, cured) for an initial smoking-related lung cancer and who stop smoking will have a decreased risk for a subsequent smoking-related cancer compared with those who continue smoking.[131,132]

Family History of Lung Cancer

Several studies have suggested an increased risk for lung cancer among first-degree relatives of patients with lung cancer, even after adjustment for age, gender, and smoking habits.[94,133,134] A meta-analysis of 28 case-control studies and 17 observational cohort studies showed an RR of 1.8 (95% CI, 1.6–2.0) for individuals with a sibling/parents or a first-degree relative with lung cancer.[135] The risk is greater in individuals with multiple affected family members or who had a cancer diagnosis at a young age. A more recent meta-analysis from the International Lung Cancer Consortium reported the same risk (1.8 [95% CI, 1.6–2.0]).[136]

Although no high-penetrance inherited syndrome has been described for lung cancer (either small cell lung cancer or NSCLC), several groups have identified genetic loci that may be associated with an increased risk of developing lung cancer.[137] The Genetic Epidemiology of Lung Cancer Consortium conducted a genome-wide linkage analysis of 52 families who had several first-degree relatives with lung cancer. Linkage disequilibrium was shown on chromosome 6, localizing a susceptibility locus influencing lung cancer risk to 6q23-25.[138] Subsequently, 3 groups performed

genome-wide association studies in patients with lung cancer and matched controls. They found a locus at 15q24-25 associated with an increased risk for lung cancer, nicotine dependence, and peripheral artery disease.[139-141] It was noted that subunits of the nicotinic acetylcholine receptor genes are localized to this area (*CHRNA5*, *CHRNA3*, and *CHRNB4*). Other investigators found that a variant at 15q24-25 is associated with spirometric bronchial obstruction and emphysema as assessed with CT.[142,143] Patients with classic familial cancer susceptibility syndromes (such as retinoblastoma and Li-Fraumeni syndrome) have a substantially increased risk for lung cancer if they also smoke tobacco.[144-146]

History of Lung Disease

Chronic Obstructive Pulmonary Disease

A history of chronic obstructive pulmonary disease (COPD) is associated with lung cancer risk,[147-153] and this association may be largely caused by smoking.[137] Yang et al[154] found that COPD is associated with 12% of lung cancer cases among heavy smokers. Data suggest that lower pack-year thresholds may be useful to trigger LDCT screening in individuals with COPD.[155] Even after statistical adjustment, evidence suggests that the association between COPD and lung cancer may not be entirely caused by smoking.[156-158] For example, 1) family history of chronic bronchitis and emphysema is associated with increased risk for lung cancer; 2) COPD is associated with lung cancer among never-smokers; and 3) COPD appears to be an independent risk factor for lung cancer.[154,158-160] Yang et al[154] found that COPD accounts for 10% of lung cancer cases among never-smokers. Koshiol et al[158] found that when they restricted their analyses to adenocarcinoma (which is more common among nonsmokers, particularly women), COPD was still associated with an increased risk for lung cancer.

Pulmonary Fibrosis

Patients with diffuse pulmonary fibrosis seem to be at a higher risk for lung cancer even after age, gender, and a history of smoking are taken into consideration (RR, 8.25; 95% CI, 4.7–11.48).[161,162] Among patients with a history of exposure to asbestos, those who develop interstitial fibrosis are at a higher risk of developing lung cancer than those without fibrosis.[163]

Hormone Replacement Therapy

It is currently unclear whether use of hormone replacement therapy (HRT) affects the risk for lung cancer in women. More than 20 studies have been published and the results have been inconsistent. Most of the currently available information comes from case-control and cohort studies. Cumulatively, these studies are variable; they have found associations ranging from an increased risk for lung cancer, no effect on risk, and a protective effect against lung cancer risk. In a large randomized controlled study,[164] no increase in the incidence of lung cancer was found among postmenopausal women treated with estrogen plus progestin HRT, but deaths from lung cancer (especially NSCLC) were higher among patients receiving HRT. No increase in lung cancer death was reported in women receiving estrogen alone.[165]

Selection of Individuals for Lung Screening

Well-known risk factors exist for the development of lung cancer, especially smoking tobacco.[3,8,9] Results from the NLST support screening select individuals who are at high risk for lung cancer.[11] The NCCN Lung Cancer Screening Panel recommends that individuals at high risk for lung cancer should be screened using LDCT; individuals at moderate or low risk should not be screened. Patients are selected for the different risk categories using the NLST inclusion criteria, nonrandomized studies, and/or observational studies. Screening with LDCT should only be recommended for select individuals at high risk if they are potential candidates for definitive treatment (ie, curative intent therapy) and have

participated in (or been offered) shared decision-making. Individuals with extensive comorbidity are not candidates for lung cancer screening if they are not candidates for curative-intent therapy. The initial risk assessment before screening needs to include an assessment of functional status to determine whether patients can tolerate curative intent treatment if they are found to have lung cancer. Chest radiography is not recommended for lung cancer screening.[11,17]

Based on the available data, the NCCN Lung Cancer Screening Panel recommends using the following criteria to determine whether individuals are at high, moderate, or low risk for lung cancer.

Individuals with High-Risk Factors

The NCCN Lung Cancer Screening Panel recommends lung cancer screening using LDCT for individuals with high-risk factors (see *Risk Status* in the algorithm). There are 2 groups of individuals who qualify as high risk:

- Group 1: Individuals aged 55 to 77 years with a 30 or more pack-year history of smoking tobacco who currently smoke or, if former smoker, have quit within 15 years (category 1).[10,11] For the 2020 update, the NCCN Lung Cancer Screening Panel extended the upper limit of the age cutoff for lung screening up to 77 years (from 74 years) when assessing whether patients are at high risk for lung cancer. In the NLST, the entry age was as old as 74 years but the screening age limit was actually up to 77 years, which also agrees with what CMS is recommending for the upper age limit.[11] Initial screening with LDCT is a category 1 recommendation for group 1, because these individuals are selected based on the NLST inclusion criteria.[10,11] The NCCN category 1 recommendation is based on high-level evidence (eg, randomized controlled trial) and uniform consensus among Lung Cancer Screening Panel members (>85%). Annual screening LDCT is recommended for these individuals with high-risk factors based on the NLST.[11] Annual screening LDCT is also recommended for those at high risk with negative LDCT scans or for those whose nodules do not meet the size cutoff for more frequent scanning or other intervention until individuals are no longer candidates for definitive treatment.[166,167] Uncertainty exists about the appropriate duration of screening and the age at which screening is no longer appropriate.[27,168]
- Group 2: Individuals aged 50 years or older with a 20 or more pack-year history of smoking tobacco who are either current or former smokers with at least one additional risk factor. NCCN Lung Cancer Screening Panel members expanded screening beyond the NLST criteria to a larger group of individuals at risk for lung cancer, which is described in greater detail in this section. LDCT screening is a category 2A recommendation for group 2.[169] These additional risk factors were previously described and include personal history of cancer or lung disease, family history of lung cancer, radon exposure, and occupational exposure to carcinogens.[81,82,84,124,128,135,158,170] Note that the NCCN Lung Cancer Screening Panel does not currently believe that exposure to second-hand smoke is an independent risk factor sufficient for recommending LDCT screening, because the data are either weak or variable (see *Exposure to Second-Hand Smoke* in this Discussion). The NCCN category 2A recommendation is based on lower-level evidence (eg, nonrandomized studies, observational data, ongoing randomized trials) and uniform consensus among NCCN Lung Cancer Screening Panel members (>85%).

NCCN Lung Cancer Screening Panel members feel that individuals in group 2 are also at high risk for lung cancer based on data from the NLST and other studies. The NCCN Lung Cancer Screening Panel feels that limiting use to the NLST criteria is arbitrary and naïve, because the NLST

only used age and smoking history for inclusion criteria and did not consider other well-known risk factors for lung cancer. Others share this opinion.[79,171,172] The NCCN Lung Cancer Screening Panel feels that it is important to expand screening beyond the NLST criteria to a larger group of individuals at risk for lung cancer.[169,173] Using just the narrow NLST criteria—shown in group 1 of the NCCN high-risk categories (eg, individuals aged 55–77 years with a 30 or more pack-year smoking history)—only 27% of patients currently being diagnosed with lung cancer would be candidates for LDCT screening.[173] Data suggest that the lung cancer risk for individuals with a 20 to 29 pack-year smoking history is similar to that of individuals with a 30 or more pack-year history.[174] Expanding the groups at high risk who are candidates for screening—for example, including individuals aged 50 or more years with a 20 or more pack-year smoking history and at least one additional risk factor (other than second-hand smoke)—may save thousands of additional lives.[36,169,175-177]

It is important to note that the NLST included both low-risk and high-risk individuals.[171,176] Only 1% of the prevented deaths occurred among individuals whose risk was 0.55% or less; almost 90% of prevented deaths were observed among individuals with a baseline risk of at least 1.24%.[171] The true risks and benefits of screening these group 2 individuals are uncertain. A risk calculator may be useful to assist in quantifying the risk for individuals in group 2 for use in a shared decision-making process.[176,178,179] Individuals in group 2 may be considered at high risk if they have additional risk factors (other than second-hand smoke) that increase the lung cancer risk above a threshold of 1.3%.[178]

In the NCCN Guidelines, the age range for LDCT was extended for individuals in group 2 (ie, ≥50 years and >77 years) for several reasons. NCCN Lung Cancer Screening Panel members feel that younger and older individuals in group 2 are also at high risk for lung cancer based on data from the NLST and other studies. Three phase 3 randomized trials assessed screening in younger patients aged 50 to 55 years of age. The NELSON screening and UKLS trials assessed LDCT in individuals 50 to 75 years of age.[61,62,65,66,68,69,71,74,180] The DLCST screened individuals 50 to 70 years of age.[64,181,182] Several studies have assessed LDCT using an extended age range of 50 to 85 years.[183-185]

It is uncertain what the age cutoff should be, where screening is no longer appropriate.[48] The NCCN Guidelines acknowledge that select individuals with high-risk factors who are older than 77 years are also candidates for LDCT. At diagnosis of lung cancer, the median patient age is 70 years.[7] Approximately 54% of lung cancer is diagnosed in patients aged 55 to 74 years; about 27% of lung cancer is diagnosed in older patients aged 75 to 84 years.[7,186] Screening may benefit older patients who are 78 to 84 years.[187] The USPSTF and the ACR recommend LDCT for individuals aged 55 to 80 years with high-risk factors.[16,35] Similarly, the American Association for Thoracic Surgery recommends LDCT for individuals aged 55 to 79 years with high-risk factors.[79] Annual screening LDCT seems reasonable for individuals older than 77 years with high-risk factors who are candidates for definitive treatment, generally defined as curative intent therapy (eg, surgery, chemoradiation, stereotactic body radiation therapy [SBRT]). Screening can be considered for individuals older than 77 years if they have good functional status, do not have serious comorbidities that would impede curative treatment, and are willing to undergo treatment.

For individuals at high risk with negative LDCT scans or those whose nodules do not meet the size cutoff for more frequent scanning or other intervention, the NCCN Guidelines suggest annual screening LDCT until individuals are no longer candidates for definitive treatment (see *Risk Status* in the algorithm). The appropriate duration of screening is uncertain.[48] After the 3 rounds of LDCT in the NLST, new cases (367 cases) of lung cancer were frequently diagnosed during the 3.5 years of

follow-up (median of 6.5 years).[11,188] The NLST and NELSON data show that lung cancer continues to occur over time in individuals with high-risk factors.[60] In addition, the incidence of lung cancer and the death rate from lung cancer did not change during the 7 years of the NLST.[189] Thus, the NLST data support annual screening LDCT for at least 2 years but do not define a time limit on efficacy. Data from the NELSON trial indicate that with a longer screening interval, there is a higher percentage of non-resolving new nodules and thus a higher percentage of lung cancers, strengthening the evidence of benefit for continued screening beyond 3 years.[190]

Individuals with Moderate-Risk Factors

NCCN defines individuals with moderate-risk factors as those aged 50 years or older and with a 20 or more pack-year history of smoking tobacco or second-hand smoke exposure but no additional lung cancer risk factors. The NCCN Lung Cancer Screening Panel and the ACR do not recommend lung cancer screening for these individuals at moderate risk for lung cancer.[35] This is a category 2A recommendation based on nonrandomized studies and observational data.[48,191] Of interest, data show that some patients in the moderate-risk group would benefit from lung cancer screening.[192]

Individuals with Low-Risk Factors

NCCN defines individuals with low-risk factors as those younger than 50 years and/or with a smoking history of less than 20 pack-years. The NCCN Lung Cancer Screening Panel and the ACR do not recommend lung cancer screening for these individuals at low risk for lung cancer.[35] This is a category 2A recommendation based on nonrandomized studies and observational data.[48,191]

Accuracy of LDCT Protocols and Imaging Modalities

Assessing Risk for Malignancy in Nodules

As shown in the NCCN algorithm, LDCT is recommended for detecting noncalcified nodules that may be suspicious for lung cancer depending on their type and size (eg, solid, part-solid, and nonsolid nodules). Most noncalcified nodules are solid.[50] Solid and subsolid nodules are the 2 main types of pulmonary nodules. Subsolid nodules include: 1) nonsolid nodules, also known as ground-glass opacities (GGOs) or ground-glass nodules (GGNs); and 2) part-solid nodules (also known as mixed nodules), which contain both ground-glass and solid components.[193-197] Nonsolid nodules that do not resolve on subsequent scans, particularly if they show gradual growth, are mainly adenocarcinomas with a lepidic component.[20,194-196,198-200] These nodules mostly consist of adenocarcinoma in situ (AIS), minimally invasive adenocarcinoma (MIA), and lepidic predominant adenocarcinomas. AIS and MIA have 5-year disease-free survival rates of 100% or near 100%, respectively, if completely resected.[20] Lepidic predominant adenocarcinomas have favorable outcomes ranging from 70% to 90% if completely resected, depending on the size and histologic patterns in the invasive components identified pathologically. Solid and part-solid nodules are more likely to be invasive and faster-growing cancers, factors that are reflected in the increased suspicion and follow-up of these nodules.[22,29,201-203] If a solid component develops in a nonsolid nodule, then the guidelines for part-solid nodules need to be used. Data suggest that long-term survival is excellent if part-solid nodules are resected.[193,204,205]

As previously mentioned, clinical risk factors associated with increased suspicion of lung cancer include age, smoking history, exposure to other carcinogens, COPD, pulmonary fibrosis, and family history of lung cancer. Many radiologic factors are associated with increased suspicion of lung cancer, including nodule size, morphology, growth rate, density, location, and irregular or spiculated margins.[201] There is an increased risk for

cancer if a nodule is located in the upper lobes, especially the right lobe.[206,207] If lung nodules have higher uptake on PET compared to mediastinal blood pool, then the nodules are suspicious for lung cancer, regardless of the standardized uptake value (SUV) analysis.[208,209]

The following factors on baseline LDCT increase the degree of suspicion that nodules may be malignant: 1) part-solid nodules; 2) pure nonsolid nodules 20 mm or more; 3) atypical subsolid nodules with spiculated contours, *bubbly* appearance, or reticulation; 4) part-solid nodules that show interval change in size or attenuation; or 5) solid lesions with characteristics that are suspicious for invasive carcinoma.[195,202,207] All nonsolid nodules should be reviewed at thin (<1.5 mm) slices to exclude any solid components.[195] If the nodule contains any solid components, then the nodule should be managed using the recommendations for part-solid nodules (see *Follow-up of Screening Findings* in the algorithm).[210,211] Pure nonsolid nodules 19 mm or less are usually AIS or MIA and may be followed with CT until they develop a change in morphology such as developing a new solid component.[195] Pure nonsolid nodules smaller than 5 mm are usually atypical adenomatous hyperplasia. Data suggest that many nonsolid nodules that resolve on subsequent scans are not adenocarcinomas, but benign inflammatory lesions, although they need to be followed.[50,212,213]

When assessing subsequent scans, the most important radiologic factors are resolution, stability, or growth of a previous nodule(s) or appearance of a new nodule(s) when compared with a previous imaging study. Rapid increase in nodule size suggests an inflammatory etiology or malignancy other than NSCLC. Data from the NELSON trial indicate that new solid nodules found during subsequent CT screening are more likely to be lung cancer than solid nodules found at baseline screening.[60] Approximately 44% of new solid nodules (50–500 mm^3) did not resolve, and 10% of them were cancer, whereas only 3% of non-resolving solid nodules at baseline were lung cancer.[60] Thus, new solid nodules need to be followed more aggressively than baseline solid nodules.[60]

Solitary pulmonary nodules pose unique challenges.[207,211,214-217] Nodule risk calculators have been published, which may be helpful when assessing solitary pulmonary nodules.[214,218] Geographic and other risk factors can influence the accuracy of nodule risk calculators. Patients who live in areas endemic for fungal disease may have granulomatous disease; the false-positive rate for PET/CT is higher for granulomas.[219-221] Multidetector CT (MDCT) of the chest has made it possible to detect very small lung nodules, both benign and malignant. The ability to acquire thinner slices, the use of maximum intensity projection (MIP) or volume-rendered (VR) images, and computer-aided diagnosis (CAD) software have increased the sensitivity of small-nodule detection.[222-236] The use of thinner images has also improved the characterization of small lung nodules.[237]

For lung cancer screening, LDCT without intravenous contrast is currently recommended (instead of standard-dose CT) to decrease the dose of radiation.[35] Although there is no strict definition of LDCT of the chest, it is usually approximately 10% to 30% of standard-dose CT. In most cases, LDCT has been shown to be as accurate as standard-dose CT for detecting solid pulmonary nodules, although nodule detection with LDCT may be limited in larger patients.[238,239] LDCT seems to be less sensitive for detecting very low-density nonsolid nodules.[240] Decreasing the radiation dose does not significantly affect the measurement of nodule size when using 1-mm thick slices.[241] These low-dose scans require radiologists to assess images that are much noisier than typical scans.[242] Studies suggest that some variation occurs in interpretation of LDCT scans among radiologists.[243-251]

LDCT Screening Protocols

LDCT lung cancer screening studies using MDCT have reported that lung cancer mortality is decreased when compared with unscreened cohorts or those receiving chest radiographs.[11,252] Studies using multidetector LDCT screening for lung cancer in individuals with high-risk factors have applied various different protocol algorithms for detection and follow-up of pulmonary nodules/lesions.[10,182,183,253-257] These protocols have been based on the positive relationships among: 1) nodule size and/or nodule consistency/density and likelihood of malignancy; 2) nodule size and tumor stage; and 3) tumor stage and survival. They also take into account the average growth rate of lung cancer (ie, volume doubling time).[258-265] Most of these protocols recommend that dynamic contrast-enhanced CT and/or PET/CT be considered for nodules that are at least 7 to 10 mm, because these technologies have been shown to increase specificity for malignancy.[23,208,211,266-270] PET has low sensitivity for nodules with less than 8 mm of solid component and for small nodules near the diaphragm. In the workup of pulmonary nodules detected with CT in a high-risk lung cancer screening population, the roles of contrast-enhanced CT and PET/CT are still in evolution.[271,272]

Currently, the most accurate protocol for lung cancer detection using LDCT is difficult to determine because of differing patient populations, methodologies, lengths of follow-up, and statistical analyses among lung cancer screening studies. LDCT screening programs (with multiple years of follow-up) report that 65% to 85% of their detected lung cancers are stage I.[58,68,75,175,256,270] The I-ELCAP (International Early Lung Cancer Action Program) and NLST are the largest series examining lung cancer detection using LDCT in individuals with high-risk factors (see *Benefits of Lung Cancer Screening* in this Discussion).[10,260] Differences in screening algorithms or recommended diagnostic pathways between these studies are summarized in Table 1.[10,260] To help ensure good image quality, all LDCT screening programs should use CT scanners that meet quality standards equivalent to or exceeding the accreditation standards of the ACR.[29]

The Fleischner Society published guidelines in 2005 for the management of incidental solid pulmonary nodules detected on CT scans.[273] The Fleischner Society subsequently published guidelines for the management of part-solid or nonsolid pulmonary nodules.[195] Because of the familiarity and/or acceptance of the Fleischner Society Guidelines among radiologists, pulmonologists, and thoracic surgeons, these same principles were incorporated into the original NCCN recommendations for lung cancer screening, although the Fleischner Society Guidelines were not aimed at the lung cancer screening population.[18] Fleischner Society Guidelines have been updated for incidental lung nodules detected after CT for other conditions (ie, not after lung cancer screening with LDCT).[201,274]

The ACR developed Lung-RADS specifically for the lung cancer screening population in order to provide a standardized reporting and management tool for clinicians.[29,38,275] Lung-RADS should be used, and not Fleischner Society Guidelines, when interpreting CT findings in an individual who has undergone lung cancer screening.[29,36,37] Lung-RADS has been shown to improve the detection of lung cancer and to decrease the false-positive results to approximately 1 in 10 screened individuals compared with more than 1 in 4 in NLST.[31,37,38,42] For subsequent LDCT scans after baseline, the false-positive result for Lung-RADS was also decreased when compared with NLST (5.3% [95% CI, 5.1%–5.5%] vs. 21.8% [95% CI, 21.4%–22.2%]).[37] The NCCN Lung Cancer Screening Panel has harmonized Lung-RADS with the NCCN Guidelines for Lung Cancer Screening by revising the nodule management algorithm for screen-detected lung nodules.[37] The NCCN threshold cutoffs for solid, part-solid, and nonsolid nodules have been rounded to the nearest whole number to harmonize with the Lung-RADS cutoffs.[29,36]

Nodules should be measured on lung windows and reported as the average diameter rounded to the nearest whole number; only a single diameter measurement is necessary for round nodules. *Mean diameter* is the mean of the longest diameter of the nodule and its perpendicular diameter. However, inter-reader variability can occur when using manual diameter measurement for assessing nodule growth, especially for nodules with spiculated and irregular margins, and can lead to misinterpretation of nodule growth.[243,244,276] Semiautomated volume measurements are more accurate for determining size and growth of pulmonary nodules; volume measurements were used in the NELSON trial, and volume measurements will probably be used moving forward.[201,243,244,276]

Optimally, these lung cancer screening protocols will increase detection of early-stage lung cancer and decrease false-positive results, unnecessary invasive procedures, radiation exposure, and cost. In at least one medical center, improvement in CT equipment and change in screening protocol have been shown to increase early lung cancer detection, decrease the surgery rate, and improve cancer-specific survival.[277] Strict adherence to a screening protocol may also significantly reduce unnecessary biopsies.[278]

NCCN Recommendations

The current NCCN recommendations in the algorithm are an adaptation of the Lung-RADS guidelines.[29,38,195,273] Studies suggested that the definition of a positive result from an LDCT scan needed to be revised, because the original definition from the NLST was associated with a high percentage of false-positive results.[11,65,279,280] In Version 1.2014 of the NCCN Guidelines for Lung Cancer Screening, the cutoff sizes for assessing solid and part-solid lung nodules on initial LDCT screening recommended by NCCN and the ACR were increased to 6 mm in diameter rather than the 4 mm originally used in the NLST and in earlier versions of the NCCN Guidelines for Lung Cancer Screening.[18,38,280,281]

The NCCN-recommended cutoff sizes for solid, part-solid, and nonsolid nodules detected on LDCT scans are shown in the algorithm. The cutoff sizes differ for nodules detected on initial screening LDCT when compared with new or growing nodules detected on follow-up and annual screening LDCT scans. There is a higher degree of suspicion for new or growing nodules and hence lower cutoff sizes are used.[60] If there is a high suspicion of lung cancer, recommendations include biopsy or surgical excision; however, tissue samples need to be sufficient and adequate to enable histology and molecular testing.[199,282,283] For nodules of borderline concern, assessment with interval LDCT scans is often recommended to determine if the nodule is changing to a suspicious form by increasing in size and/or by having a new or growing solid component.

For solid or part-solid nodules, the NCCN definition of a positive initial screening scan is a nodule measuring *6 mm* in mean diameter (see the algorithm).[12,22,37,68,284] For nonsolid nodules, the NCCN definition of a positive initial screening scan is *20 mm* in diameter*;* nodules of this size require a short-term follow-up LDCT scan in 6 months to assess for malignancy. The NCCN Guidelines emphasize that nonsolid lesions must be evaluated using thin slices (<1.5 mm) to increase the sensitivity for a solid component and to detect subtle changes over time.[194,195,227,228,237] Specific recommendations for other types of nodules, other size ranges, and different types of LDCT scans (ie, initial, follow-up, annual) are provided in the NCCN Guidelines. For example, an immediate chest CT with contrast and/or PET/CT is recommended to assess for malignancy for the following nodules detected on an initial screening LDCT: 1) solid nodules of 15 mm or more; and 2) part-solid nodules with a solid component of 8 mm or more.

If a new or growing nodule is detected on follow-up interim scans or subsequent annual screening LDCT scans, the definition of a positive scan is different because these nodules are associated with higher

risk.[60,285] If a new solid nodule is detected on follow-up or subsequent annual screening LDCT scans, the cutoff threshold is decreased to 4 mm (see the algorithm). For new part-solid nodules with a *solid component of 4 mm*, an immediate chest CT with contrast and/or PET/CT is recommended to assess for malignancy. Again, if a new or growing nonsolid nodule is detected on follow-up interim scans or subsequent annual LDCT scans, follow-up recommendations are different (see the algorithm). LDCT after 6 months is recommended for new nonsolid nodules of 20 mm or more followed by annual LDCT for stable nodules.[285] Biopsy and surgical excision are not recommended, because these nonsolid nodules are often caused by pneumonia or are AIS with little malignant potential unless they are enlarging and/or developing part-solid components. As previously mentioned, rapid increase in size and/or multiple nodules suggest an inflammatory etiology or malignancy other than NSCLC. If findings suggest infection or inflammation, a follow-up LDCT is suggested within 1 to 3 months.

In Lung-RADS, nodule growth is defined as an increase in size of *more than 1.5 mm*.[19,247] Part-solid nodule growth was defined as an increase in size of *more than 1.5 mm in the solid component* in the NCCN algorithm. However, the NCCN Lung Cancer Screening Panel did not feel they could provide guidance for an increase in the nonsolid component of part-solid nodules (eg, nonsolid nodules are difficult to measure).[29,201] This definition of nodule growth is based on intraobserver and interobserver variability when measuring small pulmonary nodules, and on the minimum change in diameter that can be reliably detected using conventional methods (excluding volumetric analysis software).[286] This definition of nodule growth is simplified compared with the formula used by I-ELCAP (see Table 1), which requires nodule growth of 1.5 to 3.0 mm in mean diameter for nodules 3 to 15 mm, depending on their diameter. The Lung-RADS and NCCN definition of nodule growth should also result in fewer false-positive diagnoses compared with the NLST suggested definition of nodule growth (≥10% increase in nodule diameter).[11]

Currently, the NCCN recommendations for lung screening do not include other possibly relevant nodule features, such as proximity to the pleura or fissure.[287-290] The topics of nodule volumetric analysis and/or calculations of tumor doubling time have also not been addressed.[172,291] The NELSON trial is using volumetric analysis, which has decreased the false-positive rate to 64%; the NLST had a false-discovery rate of 96.4% and a false-positive rate of 23.5%.[47,68,71,253] Approximately 2% of individuals had a positive initial test result in the NELSON trial compared with 24% in the NLST.[58] In some cases, it may be appropriate to perform standard-dose CT with intravenous contrast for follow-up or further evaluation of lung or mediastinal abnormalities detected on screening LDCT. If endobronchial nodules are suspected, then LDCT is recommended in 1 month or less (see *Follow-up of Screening Findings* in the algorithm). If there is no resolution, then bronchoscopy is recommended. The technician should ask the patient to cough vigorously just before LDCT, then the LDCT should be done immediately.

A table on recommended LDCT acquisition parameters is included in the algorithm, which includes Lung-RADS [see *Low-Dose Computed Tomography Acquisition, Storage, Interpretation, and Nodule Reporting (Lung-RADS)* in the algorithm].[37] For the 2020 update, the NCCN Lung Cancer Screening Panel added information about CAC scoring to this table.[292-294] Use of MIP, VR, and/or CAD software is highly recommended in addition to evaluation of conventional axial images for increased sensitivity of small nodule detection. A detector collimation of 1.5 mm or less is necessary for optimal use of these 3-dimensional applications. For accurate nodule volumetric analysis, some radiologists feel that a detector collimation of 1 mm or less is needed. Measurement and evaluation of small nodules are more accurate and consistent on 1-mm thick images

compared with 5-mm images.[237] There may be a similar but less-pronounced benefit in evaluating nodules on 1-mm reconstructed images after detecting them on 2.5- to 3.0-mm thick slices.

The preferred slice width is 1 mm or less, and the acceptable slice width is 2.5 mm or less based on Lung-RADS.[37,38,195,227] Nonsolid lesions must be evaluated at thin slices (<1.5 mm) to exclude solid components.[195] Part-solid nodules have higher malignancy rates than either solid nodules or pure nonsolid nodules and, therefore, require rigorous evaluation.[195] Because slice thickness, reconstruction algorithms, and postprocessing filters affect nodule size measurement, the same technical parameters should be used for each screening LDCT (eg, the same window/width and window/level settings).[242,295] Ultra-low-dose chest CT currently produces lower sensitivity for nodule detection, especially in larger patients.[239] New LDCT technologies may make it possible to significantly decrease the radiation dose without compromising nodule detection and evaluation.[296-299] Some organizations, including the ACR, recommend using CT dose tracking for all CT screening programs to ensure that screening facilities are adhering to acceptable radiation limits (eg, reporting the dose-length product [DLP] for each CT).[300]

Multiple Nonsolid Nodules

As previously mentioned, subsolid nodules include 1) nonsolid nodules (also known as GGOs or GGNs); and 2) part-solid nodules (also known as mixed nodules), which contain both ground-glass and solid components.[194-197] Subsolid nodules may contain part-solid or solid components, which increase the possibility of malignancy. When multiple subsolid nodules occur, the dominant lesion should be assessed.[22] Careful assessment is needed to determine whether patients have: 1) a malignant nodule and several benign nodules; 2) several synchronous lung cancers; or 3) a dominant malignant nodule with metastases.[301] Multiple nodules may also be due to inflammation or infection, especially if they are rapidly expanding in size.[22]

Benefits and Risks of Lung Cancer Screening

The goal of screening is to identify disease at an early stage while it is still treatable and curable. The potential huge benefits of lung cancer screening include a reduction in mortality and improvement in quality of life.[26,302,303] The risks of lung screening include false-negative and false-positive results, radiation exposure, overdiagnosis of incidental findings, futile detection of aggressive disease, anxiety, unnecessary testing, complications from diagnostic workup, and financial costs.[25,302-308] Most lung nodules found on LDCT are benign; if possible, these nodules should be assessed using noninvasive procedures to avoid the morbidity of invasive procedures in patients who may not have cancer.[306,309] The risks and benefits of lung cancer screening should be discussed with the individual before LDCT screening is initiated (see *Shared Decision-Making* in this Discussion).

Benefits of Lung Cancer Screening

This section summarizes information about the possible or projected benefits of screening for lung cancer using LDCT scans, including: 1) decreased lung cancer mortality, or improvement in other oncologic outcomes; 2) quality-of life benefits from screening and early detection of cancer (compared with standard clinical detection); and 3) detection of disease, other than lung cancer, that requires treatment.[14,27,44,48,189,302] Effective lung screening may prevent more than 12,000 premature lung cancer deaths per year.[310] Other occult health risks may be identified such as thyroid nodules, COPD, moderate to severe CAC, aortic aneurysm, other cancers (eg, breast cancer, renal cancer), and other conditions.[311]

Oncology Outcomes

After a clinical diagnosis of NSCLC, survival is directly related to stage at diagnosis.[312] Although patients with earliest-stage disease (IA) may have a 5-year survival rate of approximately 75% with surgery, the outcomes quickly decrease with increasing stage (eg, 5-year survival is 71% for stage IB; 58% for IIA; 49% for IIB; and <25% for stages III and IV).[313] Note that current staging for NSCLC uses the 2017 AJCC staging system (8th edition) (see the NCCN Guidelines for Non-Small Cell Lung Cancer, available at www.NCCN.org).[314] The AJCC Cancer Staging Manual was recently revised (8th edition) and is effective for all cancer cases recorded on or after January 1, 2018.[314,315] Although it is intuitively appealing to conclude that earlier detection of disease will improve outcome, screen-detected lung cancers may have a different natural history from that of clinically detected cancers[316,317] and an apparent increase in survival from early detection itself (lead-time bias). Pathology results of resected lung cancers detected through prior screening trials suggest that screening increases the detection of indolent cancer. However, randomized trial data from the NLST and preliminary data from the NELSON trial show that LDCT screening decreases lung cancer mortality.[11,58]

Nonrandomized Trials

Of the nonrandomized screening studies, the I-ELCAP study is the largest.[52] It included 31,567 individuals with high-risk factors from around the world, all of whom were screened with baseline and annual screening LDCT scans analyzed centrally in New York.[260] In the I-ELCAP study, Henschke et al[260] reported that a high percentage of stage I cancers (85%) were detected using LDCT, with an estimated 92% actuarial 10-year survival rate for stage I cancers resected within 1 month of diagnosis (62% of all cancers detected). Three participants with clinical stage I cancer—who opted not to undergo treatment—all died within 5 years, similar to other data examining the natural history of stage I NSCLC.[318,319] The authors concluded that annual screening LDCT can detect lung cancer that is curable. Important caveats about the I-ELCAP study include that it was not randomized, the median follow-up time was only 40 months, and less than 20% of the subjects were observed for more than 5 years. Given the limited follow-up, the 10-year survival estimates may have been overstated.

A study by Bach et al[320] raised concern that LDCT screening may lead to overdiagnosis of indolent cases without substantially decreasing the number of advanced cases or the overall attributable deaths from lung cancer. Although overdiagnosis did occur with LDCT in the NLST, the magnitude was not large when compared with radiographic screening (83 vs. 17 stage IA bronchioloalveolar carcinoma).[11,20,188] An analysis of the NLST data stated that 18% of all lung cancers detected by LDCT seemed to be indolent.[28] Data suggest that baseline CT scans find more indolent cancers, and subsequent annual scans find more rapidly growing cancers.[12,13,60,321]

Randomized Trials

To address the concerns of bias and overdiagnosis from nonrandomized screening studies, the NCI launched the NLST in 2002.[10] The NLST was a prospective, randomized lung cancer screening trial comparing annual screening LDCT scans with annual chest radiographs for 2 years; this trial was designed to have 90% power to detect a 21% decrease in the primary endpoint of lung cancer-specific mortality in the screened group. The investigators enrolled 53,454 individuals aged 55 to 74 years who had smoking history of at least 30 pack-years. If subjects were no longer smoking tobacco, they had to have quit within the previous 15 years. The NLST results showed that annual screening LDCT decreased the RR of death from lung cancer by 20%.[11] Overall, 24% of the LDCT scans and 7% of the chest radiographs performed were positive screens, an imbalance that was expected based on prior data. In each of the 3 rounds of

screening, positive LDCT scan screens were determined to be actual lung cancer cases (ie, true-positive) 4%, 2%, and 5% of the time, compared with 6%, 4%, and 7% of the time for positive chest radiographs.

Based on the published NLST results, 356 participants died of lung cancer in the LDCT arm and 443 participants died of lung cancer in the chest radiograph arm.[11] Thus, annual screening LDCT decreased the RR of lung cancer death by 20% in the NLST. These results are impressive, and the NLST represents the first randomized study showing an improvement in disease-specific mortality when using a lung cancer screening program.[12] The NLST results indicate that to prevent one death from lung cancer, 320 individuals with high-risk factors must be screened with LDCT.[11] The NLST results have changed medical practice in the United States.

Some clinicians feel that the 20% reduction in lung cancer mortality from LDCT screening (compared with chest radiography) in the NLST may actually be greater in clinical practice, because the observed mortality reduction underestimates the true reduction and because chest radiographs are not currently recommended for lung cancer screening as standard practice.[215,322,323] In stop screening trials, such as the NLST, deaths during prolonged follow-up may have been prevented if screening had been continued.[322,324] Thus, if annual lung screening is continued for more than 2 years, this increased screening may yield lung cancer mortality reductions of more than 20% (which was reported by the NLST after annual lung screening for only 2 years). Findings suggest that showing the benefit of breast cancer screening requires follow-up of at least 20 years.[325] Others feel that the mortality benefit from screening for lung cancer with LDCT will vary substantially across patients who differ in their baseline risk of developing lung cancer.[326] Preliminary data from the NELSON randomized trial report that 904 patients died in the LDCT screening arm compared with 934 patients in the no screening arm.[58] Smaller randomized trials, such as the DLSCT trial, have not reported that LDCT screening decreases mortality.[181,327] The MILD trial was underpowered to detect a difference in mortality.[50,327] Recent data from the MILD trial demonstrated a benefit to long-term LDCT screening.[328] After 10 years of screening, the LDCT arm yielded a 39% decreased risk of lung cancer mortality (HR, 0.61 [95% CI, 0.39–0.95]). The benefit of screening improved beyond the fifth year with a 58% decreased risk of lung cancer mortality (HR, 0.42 [95% CI, 0.22–0.79]).

Approximately 8.6 million individuals were eligible for LDCT lung screening in 2010 using the NLST definitions of high risk. It was estimated that 12,250 deaths would be averted if these high-risk individuals received LDCT screening.[310] If NCCN group 2 criteria were also used to identify high-risk individuals, then an additional 2 million individuals would also receive lung screening and an additional 3000 deaths would be averted.[169]

Quality of Life

The NLST assessed quality of life among participants at the time of each annual screening study.[329] Possible quality-of-life benefits from early lung cancer detection (as opposed to detection at the time of clinical symptoms) include: 1) reduction in disease-related morbidity; 2) reduction in treatment-related morbidity; 3) alterations in health affecting lifestyles; and 4) reduction in anxiety and psychological burden. Presumably, quality of life is also improved with negative LDCT findings, although the need for continued follow-up may increase anxiety.

Reduction in Disease-Related Morbidity

It is a reasonable assumption that the disease-related symptom burden would be decreased in patients whose lung cancer is detected early (via screening) compared with late (via clinical presentation). Most patients whose lung cancer is detected early are asymptomatic, and detection is often either incidental or part of a screening protocol.[10,201] Historically, most patients with lung cancer presented with symptoms of the disease (including cough, dyspnea, hemoptysis, pain, weight loss, and cachexia),

and thus their lung cancer was detected clinically. In addition, lung cancer screening may identify other clinical conditions unrelated to lung cancer that require follow-up (eg, CAC, COPD, other cancers); presumably, treatment of these other conditions will decrease the overall disease burden.[11,22,330-333] For the 2020 update, the NCCN Lung Cancer Screening Panel feels that reporting the presence of CAC detected on chest CT may be useful as a marker of atherosclerosis.[292,293] CAC may be reported using either a visual score (ie, none, mild, moderate, severe) or a quantitative score (such as the Agatston score).[292] Further evaluation is recommended if CAC is severe.

Reduction in Treatment-Related Morbidity

Patients with early-stage NSCLC primarily are treated surgically, sometimes with adjuvant chemotherapy, whereas those with more advanced disease are treated with a combination of systemic therapy and radiation, or systemic therapy alone (see the NCCN Guidelines for Non-Small Cell Lung Cancer, available at www.NCCN.org).[334,335] Patients with early-stage NSCLC who undergo an R0 resection have increased survival compared with those with more advanced disease who undergo definitive chemoradiation therapy.[336] Few data have been published comparing the treatment burden of surgery versus chemoradiation therapy. It seems reasonable to assume that a patient with stage I NSCLC requiring a lobectomy alone (or SBRT, also known as stereotactic ablative radiotherapy [SABR]) probably has less treatment-related morbidity than a patient with stage III NSCLC requiring combined-modality therapy (ie, chemotherapy, radiation, possible lung resection).[337,338] However, a difference in morbidity has not been shown.

The NLST found that 40% of the cancers detected in the CT-screening group were stage IA, 12% were stage IIIB, and 22% were stage IV.[11] Conversely, 21% of the cancers detected in the chest radiograph group were stage IA, 13% were stage IIIB, and 36% were stage IV. These results suggest that LDCT screening decreases the number of cases of advanced lung cancer, and therefore may decrease treatment-related morbidity. Data from the NELSON and UKLS trials also suggest that CT screening detects more early-stage lung cancer.[58,62,68] Lung cancer screening may reduce the number of patients who require pneumonectomy for treatment of lung cancer, which will reduce treatment-related morbidity and mortality. Several series have shown that pneumonectomy is performed in only 1% of cases of lung cancer diagnosed in CT screening programs, in contrast to the 20% to 30% rate of pneumonectomy in symptom-detected cases.[339-342]

Patients with early-stage NSCLC may be candidates for treatment that would not be appropriate for those with advanced stage disease. Video-assisted thoracopic surgery (VATS) is an option for patients with early-stage NSCLC (eg, those who may not tolerate or may refuse an open lobectomy).[343-346] VATS lobectomy is associated with less morbidity than open lobectomy. SBRT is a recommended option for patients with early-stage NSCLC who are not candidates for surgery.[337,347-349]

Alterations in Health That Affect Lifestyles

The process of lung cancer screening itself has been suggested to increase smoking cessation rates. Conversely, it has also been suggested that negative results on a lung cancer screening test may provide a false sense of security to smokers and result in higher smoking rates.[350] Neither hypothesis has been supported by any substantial evidence.[351-353] Studies suggest that smoking cessation rates were higher when more follow-up LDCT scans were ordered for abnormal findings, regardless of ultimate diagnosis of cancer, suggesting that patients became scared into quitting.[351,354] In a controlled study, smoking abstinence rates were similarly higher than expected in both screened and unscreened arms. This result suggests that the positive effect on smoking cessation was likely unrelated to the screening test results and may reflect a higher desire to be healthy

among volunteers participating in screening clinical trials.[355] A study in more than 1400 individuals reported that relapse rates were lower in patients with positive scans who had stopped smoking for 2 years or less.[356]

Smokers, including those undergoing lung cancer screening, should always be encouraged to quit smoking tobacco (see the NCCN Guidelines for Smoking Cessation, available at www.NCCN.org).[357-359] Likewise, former smokers should be encouraged to remain abstinent. Lung cancer screening is not a substitute for smoking cessation.[360] Programs using behavioral counseling combined with medications that promote smoking cessation (approved by the FDA) can be very useful in helping individuals to quit smoking.[360-362]

Reduction in Anxiety and Psychological Burden

Whether lung cancer screening causes anxiety or improves overall quality of life has been assessed in the NLST and NELSON trials. In the NLST trial, patients with either a false-positive result or significant incidental finding did not report increased anxiety or differences in quality of life at 1 or 6 months after screening.[329] In the NELSON trial, recipients of an indeterminate result from the LDCT scan experienced increased distress in the short term, whereas relief was experienced after a negative baseline screening examination.[363] After 2 years of follow-up, data from the NELSON trial suggest that lung screening did not adversely affect quality of life.[364] In the UKLS trial, screening was not associated with clinically significant long-term anxiety, depression, or distress in individuals at high risk for cancer.[365] Further longitudinal studies are needed to determine the long-term effect. Patients' attitudes toward risk in their life (risk perception) also greatly affect their anxiety when undertaking cancer screening examinations.[366] Little definitive research is available to support or refute effects on quality of life from lung cancer screening.

Risks of Lung Cancer Screening

Lung cancer screening with LDCT has inherent risks and benefits.[26,27,48,188,367] These risks must be understood to determine whether screening is beneficial. The possible or projected risks of screening for lung cancer using LDCT scans include: 1) false-positive results, leading to unnecessary testing, unnecessary invasive procedures (including surgery), increased cost, and decreased quality of life because of mental anguish; 2) false-negative results, which may delay or prevent diagnosis and treatment because of a false sense of good health; 3) futile detection of small aggressive tumors (which have already metastasized, preventing meaningful survival benefit from screening); 4) futile detection of indolent disease (ie, overdiagnosis), which would never have harmed the patient who subsequently undergoes unnecessary therapy; 5) indeterminate results, leading to additional testing; 6) radiation exposure; and 7) physical complications from diagnostic workup. Patients with several comorbid conditions may be at greater risk than those with few or none. Therefore, the initial risk assessment before screening needs to include an assessment of functional status to determine whether patients can tolerate curative intent treatment if they are found to have lung cancer. Patients with extensive comorbidity may not be candidates for lung cancer screening, because treatment for lung cancer might not prolong survival and could cause potential morbidity and mortality.

False-Positive Results

Lung cancer screening studies (which have included only high-risk populations) have found a high rate of noncalcified nodules larger than 4 mm on LDCT screening, with false-positive rates ranging from 10% to 43%.[184,341,368-371] In the NLST, the false-discovery rate was 96.4% and the false-positive rate was 23.5% for the CT screening group.[11] The cumulative risk of a false-positive result was 33% for a person undergoing lung cancer screening with 2 sequential annual examinations.[368] Thus, LDCT had a high rate of sensitivity but a low rate of specificity in the

NLST. These false-positive results in the NLST were probably due to benign intrapulmonary lymph nodes and noncalcified granulomas.[11,23] Data from the NELSON trial show that using volumetric analysis decreases the false-positive rate.[71,253] Use of the Lung-RADS protocol has been shown to decrease the false-positive rate and increase the detection of lung cancer.[36-38] A lung cancer screening study in 2106 veterans reported a high false-positive rate in lower-risk veterans but a lower false-positive rate in higher-risk veterans, although this was confounded by identifying a majority of positive nodules that would have been considered negative by current Lung-RADS criteria.[76,77] False-positive reporting overestimates the risk of unintended harm because only a percentage of positive findings are considered for invasive tissue diagnosis.[39]

False-positive and indeterminate results require follow-up, which may include surveillance with chest LDCT scans, percutaneous needle biopsy, or even surgical biopsy. Each of these procedures has its own risks and potential harms.[372] Approximately 7% of individuals with a false-positive result will undergo an invasive procedure (typically bronchoscopy).[368] In the NLST, the rate of major complications after an invasive procedure was very low (only 0.06%) after workup for a false-positive result in the CT screening group.[11] A study reported that veterans were less concerned about health risks from lung cancer screening and more concerned about personal risk for cancer.[373]

Bach et al[320] also provide insight into the potential harms of LDCT screening, which results in a 3-fold increase in lung cancer diagnosis and a 10-fold increase in lung cancer surgery; this represents substantial psychological and physical burdens. Although the I-ELCAP investigators reported a surgical mortality rate of only 0.5% (when surgery is performed by board-certified thoracic surgeons at cancer centers), the average surgical mortality rate for major lung surgery across the United States is 5%, and the frequency of serious complications is greater than 20%.[374]

These potential harms associated with thoracic surgery[374-376] mandate that the effectiveness of LDCT screening be accurately assessed. Methods of decreasing potential harms with thoracic surgery include using treatment with less morbidity (eg, sublobar resection, VATS lobectomy, SBRT), using minimally invasive diagnostics (endobronchial ultrasound and navigational bronchoscopy), and using experienced, dedicated, multidisciplinary teams to minimize unnecessary testing and procedures and the morbidity of those procedures.

The NCCN recommendations for lung cancer screening may avoid much of the most invasive follow-up for noncalcified nodules that are detected on baseline screening with LDCT (see *Screening Findings* in the algorithm). The NCCN screening recommendations use the NLST and I-ELCAP protocols/recommendations (see Table 1), Lung-RADS recommendations, and the Fleischner Society Guidelines and are based on expert opinion from NCCN Lung Cancer Screening Panel members.[11,37,195,201,273,377] Repeat chest LDCT scanning is associated with risk for: 1) increased radiation exposure; 2) increased cost of follow-up scans and clinic visits; and 3) ongoing anxiety for the individual, who must wait for the results of repeat chest LDCT scans.[43,378]

False-Negative Results

Sone et al[379] published 2 reports on lung cancers missed at screening.[380,381] Of the 88 lung cancers diagnosed, 32 were missed on 38 LDCT scans: 23 from detection errors (with a mean size of 9.8 mm) and 16 from interpretation errors (with a mean size of 15.9 mm). Detection errors included: 1) subtle lesions (91%) appearing as nonsolid nodules; and 2) lesions (83%) that were overlapped with, obscured by, or similar in appearance to normal structures (such as blood vessels). Interpretation errors (87%) were seen in patients who had underlying lung disease, such as tuberculosis, emphysema, or fibrosis.[215]

The second report revealed that 84% of missed cancers in that database were subsequently detected using an automated lung nodule detection method. The CAD method involved the use of gray-level thresholding techniques to identify 3-dimensionally contiguous structures within the lungs, which were possible nodule candidates. The problem is that CAD systems are not universally deployed, and the success of detecting disease can vary greatly among radiologists. The variability and success of CAD and volumetric analysis systems may also affect the success of screening trials.[243,244] A database of lung nodules on CT scans provides an imaging resource for radiologists, which may help to decrease false-negative and false-positive results.[224]

The range in variability at various centers, particularly outside of academic institutions, may lead to significant differences in results compared with those published from clinical trials. Variability occurs when assessing subsolid nodules.[245-247] False-negative results from a screening test may provide an individual patient with a false sense of security, causing a patient to perhaps ignore symptoms that may have otherwise led to more evaluation.

Futile Detection of Small Aggressive Tumors

Early detection using lung cancer screening may not be beneficial if a small tumor is very aggressive and has already metastasized, with a loss of opportunity for effective treatment. Studies show that a 5-mm lung cancer has undergone approximately 20 doublings yielding 10^8 cells, whereas patient death typically occurs with a tumor burden of 10^{12} cells.[382] Even small tumors may have already metastasized. Studies have also shown that metastases can occur at the time of angiogenesis, when lesions are approximately 1 to 2 mm.[383]

The NLST and NELSON trial results show that lung cancer screening is effective in select individuals with high-risk factors.[11,58] The data from these trials show that detecting and treating lung lesions lead to a reduction in lung cancer–specific mortality. Therefore, the likelihood of futile therapy in patients with screen-detected tumors is much less. Because the natural history of lung cancer is heterogeneous and not completely predictable,[384] the potential remains for futile treatment in patients with an aggressive tumor that is already incurable at the time of screening diagnosis.

Futile Detection of Indolent Disease

Although lung cancer specialists generally have a strong opinion of the uniform fatality of untreated lung cancer, studies of some low-grade lung cancers (ie, lepidic adenocarcinoma) show a potential for prolonged survival in some patients with NSCLC, even without therapy.[385,386] AIS and MIA, which are likely to present as nonsolid nodules, have 5-year disease-free survival rates of 100% or near 100%, respectively, if completely resected.[20,385] Lepidic predominant adenocarcinomas have favorable outcomes ranging from 70% to 90%, if completely resected. A greater percentage of the lepidic pattern, which corresponds with the nonsolid component in a part-solid nodule, is correlated with a more favorable prognosis.[20,385,386]

Furthermore, experience in lung cancer screening has raised the question of increased identification of indolent tumors in the screened population, which is termed *overdiagnosis*.[320,387] These indolent tumors may not cause symptoms or cancer mortality; therefore, patients do not benefit from screening and subsequent workup and treatment. A percentage of these patients will be exposed to the risk, morbidity, and mortality of surgical resection that, in retrospect, will not increase their life expectancy. AIS and MIA have excellent survival and should be separated from overtly invasive adenocarcinomas; therefore, surgical intervention for pure nonsolid nodules should be minimized by using CT screening protocols and multidisciplinary decision-making.[20,37]

Overdiagnosis is difficult to measure; initial estimates from the NLST suggested that it was 13%, but others suggested it may have been as high

as 25%.[50,388] An analysis of the NLST data reported that 18% of all lung cancers detected by LDCT seemed to be indolent.[28] Bach et al[320] found an increase in the number of patients with lung cancer detected through screening, yet found no evidence of a decline in the number of deaths from lung cancer. Their nonrandomized study raised concern that LDCT screening may lead to overdiagnosis of indolent cases and to the morbidity of treatment, without a survival benefit. However, the randomized NLST and NELSON trials found that LDCT does decrease lung cancer mortality.[11,58]

Quality of Life

The effect of lung cancer screening on the quality of life (see *Benefits of Lung Cancer Screening* in this Discussion) is not fully known. A study by van den Bergh et al[389] found no measured adverse effects, although approximately half of the participants reported discomfort while waiting for the results. Several studies (including the NLST and NELSON trial) have measured quality-of-life issues.[363,364] Data from the NLST and NELSON trials suggest that lung screening did not adversely affect quality of life.[329,364] False-positive and indeterminate results may decrease quality of life because of mental anguish and additional testing.[25]

During the NLST, 3 rounds of LDCT screening were done (ie, baseline, year 1, year 2) and then individuals were followed for an additional 3.5 years. Lung cancer was diagnosed between annual screens in some patients (ie, interval cancers); lung cancer was also diagnosed during follow-up.[11,390] Thus, individuals should be cautioned that LDCT may not identify all lung cancers or prevent death from lung cancer.[11] In addition, they should be informed that a positive test result does not mean they have lung cancer because false-positive results occur with LDCT.[43]

Unnecessary Testing

Any lung cancer screening program will result in additional testing. In a report by Croswell et al[391] (from the PLCO trial), the cumulative risk of having one false-positive result was 60% for men and 49% for women. The cumulative risk of undergoing an invasive diagnostic procedure prompted by the false-positive test was 29% for men and 22% for women. The NLST was a carefully supervised randomized controlled trial. In a less-controlled environment, the rate of additive studies may be higher. Sistrom et al[392] reviewed the recommendations for additional imaging in more than 5.9 million radiology reports; they reported additional imaging of 35.8% for chest LDCT. The issue of incidental findings on screening examinations is problematic, and some organizations are attempting to address the issue, but regional and physician variations remain.[393]

Radiation Exposure with LDCT

Current MDCT scanners provide a significantly enhanced capability for detecting small nodules through allowing thinner slice images. Using low-dose techniques, the mean effective radiation dose is 1.5 millisievert (mSv) (standard deviation [SD], 0.5 mSv) compared with an average of 7 mSv for conventional CT.[11,14,50,394] The radiation dose of LDCT is 10 times that of chest radiography.

There may be even more reason to be concerned about use of chest LDCT scans for lung cancer screening, because these individuals, who are already at high risk for lung cancer, may experience adverse effects from increased radiation exposure. In fact, the effects of repeated exposure to radiation at regular intervals are not known. Brenner[395] estimated a 1.8% increase in lung cancer cases if 50% of all current and former smokers in the United States between 50 and 75 years of age were to undergo annual screening LDCT. Lower doses of radiation are now used for LDCT scans and these lower doses may be less dangerous.[396,397] Radiation exposure from lung cancer screening using LDCT and PET/CT is greater for woman than for men.[304] For men, the median cumulative effective dose was 9.3 mSv after 10 years of screening; the dose was 13.0

mSv for women. These doses are equivalent to one standard CT of the chest (7–8 mSv).

Increased Cost

Many are concerned about the effect of lung cancer screening on medical resources, including the cost of LDCT screening and additional testing. The estimated cost of an LDCT scan is about $334 (U.S. national average).[398] Approximately 14% of the U.S. adult population (about 34.3 million people) are active cigarette smokers.[85,87,89,399] It is estimated that about 900,000 veterans will be eligible for lung cancer screening.[76] In 2015, the number of individuals at high risk who were candidates for lung cancer screening was approximately 6 million (using NLST criteria).[11,400] Depending on the screening rate (50% or 75%), the annual cost in the United States is estimated to be about $1.7 to $3.4 billion.[398,400] If 75% of the eligible high-risk population has screening, it is estimated that it will cost $240,000 to prevent one lung cancer death.[44] It is estimated that $18 billion will be spent in 2020 on lung cancer care in the United States.[398,401] However, what has not been factored is the potential cost savings of shifting to lung cancer therapy for an earlier stage of disease (ie, the cost of surgical therapy for early-stage disease versus the cost of systemic therapy for advanced disease). Recent estimates of the cost of lung cancer care for Medicare patients do not include immunotherapy.[402]

LDCT screening will lead to false-positive results, detection of indeterminate nodules, and detection of potential disease other than lung cancer.[329] In the NLST, although 24.2% of the LDCT scans were initially flagged as “positive”, the false-discovery rate was 96.4% and the false-positive rate was 23.5%.[11] Follow-up for positive nodules typically involves further imaging.[11] Assuming a 50% screening rate, a conservative estimate of the annual cost of working up false-positive nodules is about $800 million (3.5 million × 23% × $1000). Use of Lung-RADS will probably decrease this cost because the false-positive rate will decrease. This estimate does not include costs of workup for other potential abnormalities detected during screening, such as cardiac and upper abdominal pathology. Of individuals with a false-positive result, approximately 7% will undergo an invasive procedure (typically bronchoscopy).[368] Thus, false-positive reporting overestimates the risk of unintended harm because only a percentage of positive findings are considered for invasive tissue diagnosis.[39] Limiting screening to only individuals with high-risk factors not only helps avoid unnecessary risks in individuals with a lower risk for cancer but also is important for decreasing the costs of the screening program. Pre-screening—based on age, smoking history, appropriate medical history, family history, and occupational history—is important to determine which patients are at high risk (see *Risk Assessment* in the algorithm).

Lack of well-defined guidelines can lead to overuse of screening. Excessive screening and/or interpretations of studies by unskilled individuals may occur without strict guidelines (as with mammography). Other factors, such as the interval at which screening should be performed, will also affect calculations of cost. In screening studies using LDCT, 23% of the ELCAP and 69% of the 1999 Mayo Clinic study had at least one indeterminate nodule. Depending on the size and characteristics of the indeterminate nodule, further evaluation may include serial follow-up LDCT, dynamic contrast-enhanced nodule densitometry, PET, or biopsy. False-positive results also lead to additional unnecessary testing and increased cost.

Lung screening also leads to detection of disease other than lung cancer, such as infection; CAC; COPD; and renal, adrenal, and liver lesions.[22,76,215,292,293,331-333,403,404] Although detection of other diseases may frequently provide a clinical benefit to the patient, costs will be further increased with additional testing and treatment. It is important to rule out infection and inflammation (see *New Nodule on Follow-Up or Annual*

LDCT in the algorithm); however, antimicrobials are not indicated for chronic lesions.[215] Inappropriate use of antimicrobials may cause adverse side effects and will increase cost. Incidental lesions may also be detected, which may require further testing (eg, intrapulmonary lymph nodes, noncalcified granulomas, thyroid incidentalomas, upper abdominal lesions).[11,76,311]

Cost-Effectiveness and Cost-Benefit Analyses

The cost-effectiveness of lung cancer screening is also important to take into account.[405] LDCT imaging is more expensive than many other screening programs, and therefore it is important to validate the effectiveness of screening.[406] Medicare reimburses approximately $242 for an LDCT scan, which is adjusted depending on geography.[398,405,407] Note that cost-benefit analysis provides dollar values for the outcomes, whereas cost-effectiveness analysis provides cost per health outcome (eg, cost per life-year gained). Seven analyses have reported a cost-effectiveness ratio of $100,000 (in U.S. dollars) or less per Quality Adjusted Life Years (QALYs) gained for LDCT, which indicates that screening is cost-effective.[408] A threshold level of $100,000 per QALY gained is what some experts consider to be a reasonable value in the United States.

A fundamental flaw with cost–benefit analyses for lung cancer screening is that the true benefit of screening requires more years of follow-up and more years of screening to realize the full potential; therefore, this crucial factor has been arbitrarily assigned or assumed in prior analyses.[325] The types of assumptions made can significantly affect the conclusions of the analysis. Furthermore, many cost–benefit analyses do not adequately represent the detrimental effects of false-positive test results on screening. For a person undergoing lung cancer screening with 2 sequential annual examinations, the cumulative risk of a false-positive test result was 33%.[368] The cost of false-positive cancer screening results has been estimated to be at least $1000 per incident.[409] The ELCAP investigators documented that diagnostic procedure costs and hospital/physician costs in the first year after the diagnosis of lung cancer proportionally increased with increasing stage.[410] An analysis using SEER-Medicare data also found that costs increase with increasing stage.[402] The incremental cost per life-year gained ratio is also very sensitive to the fraction of the patients screened and found to have early-stage disease; the higher the percentage of patients found with early-stage disease, the lower the incremental cost ratio.[411]

Shared Decision-Making

Given the high percentage of false-positive results and the downstream management that ensues for many patients, the risks and benefits of lung cancer screening should be discussed with the individual before a screening LDCT scan is performed.[26,27,43,44,279,373,412] Individuals should be cautioned that LDCT may not identify all lung cancers or prevent death from lung cancer.[11] In addition, they should be informed that a positive test result does not mean they have lung cancer because false-positive results occur with LDCT.[43] Patients should also be aware that LDCT screening is an ongoing process that involves annual (or more frequent) testing for many years. Shared patient/physician decision-making may be the best approach before deciding whether to do LDCT lung screening, especially for elderly patients with comorbid conditions.[16,45,46,413] Smoking cessation counseling is recommended.[357,414] Lung screening is not recommended for patients who are not able or willing to have curative therapy because of health problems or other major concerns.[16] Thus, the initial risk assessment before screening needs to include an assessment of functional status to determine whether patients can tolerate curative intent treatment if they are found to have lung cancer.

Shared decision-making aids may assist when determining if screening should be recommended (see the algorithm). In addition, risk calculators may be used to assist with decision-making for group 2 in the NCCN

Guidelines (ie, individuals ≥50 years with a ≥20 pack-year smoking history) and also for group 1 (NLST criteria).[178] It is well established that risk calculators can identify patients in group 1 who are actually low risk and should not be screened and identify individuals in group 2 who are high risk and should be screened. For example, the Tammemagi risk calculator includes additional variables that can be used to help determine whether individuals in group 2 are candidates for screening.[415] The additional variables include body mass index (BMI), history of COPD, education level, chest x-ray in the last 3 years, and family history of lung cancer. Using this risk calculator, the threshold for screening is 1.34% to 1.51%.[178,415] Previous lung cancer screening results can also be used for risk stratification.[167,180] The Tammemagi risk calculator was used to assess 7044 individuals (PanCan study), and an increased incidence of early-stage lung cancer was observed when compared with the NLST (Tammemagi: 133/172 [77%] vs. NLST: 593/1040 [57%]; *P* < .0001).[415]

Summary

Lung cancer screening with LDCT is a complex and controversial topic, with inherent risks and benefits. Results from the randomized NLST showed that screening with LDCT decreased the RR of death from lung cancer by 20% in a select group of individuals with high-risk factors, such as history of heavy cigarette smoking.[11] The NLST results indicate that to prevent one death from lung cancer, 320 individuals at high risk must be screened with LDCT. Preliminary data from the NELSON trial suggest that LDCT decreases lung cancer mortality in both men and women at high risk for lung cancer compared with no screening.[58] Seven analyses have reported a cost-effectiveness ratio of $100,000 (in U.S. dollars) or less per QALYs gained for LDCT, which indicates that screening is cost-effective.[408] A threshold level of $100,000 per QALY gained is what some experts consider to be a reasonable value in the United States.

The NCCN Lung Cancer Screening Panel recommends LDCT screening for select individuals at high risk for lung cancer based on the NLST results, nonrandomized studies, and observational data.[11] These NCCN Guidelines discuss in detail the criteria for selecting patients at high risk for lung cancer who may benefit from LDCT screening, and the algorithm provides recommendations for evaluating and following up nodules detected on LDCT screening (eg, solid, part-solid, and nonsolid nodules). The cutoffs for assessing suspicious nodules on baseline screening LDCT were revised to decrease the false-positive rate in Version 1.2014 of the NCCN Guidelines for Lung Cancer Screening. For solid or part-solid nodules, the NCCN definition of a positive screening scan is a solid nodule measuring 6 mm on baseline screening LDCT. For nonsolid lesions, the NCCN-recommended cutoff is 20 mm on baseline screening.[285] The cutoffs are slightly lower for suspicious nodules that are detected on follow-up interim scans or subsequent annual screening LDCT scans, because these new or growing nodules are associated with higher risk. The ACR has developed Lung-RADS to standardize the reporting and management from LDCT lung examinations.[38,275] Lung-RADS has been reported to improve the detection of lung cancer and to decrease the false-positive rate.[31,37,38,42] The NCCN cutoff thresholds for solid, part solid, and nonsolid nodules are harmonized with the Lung-RADS cutoffs.[37] False-positive reporting overestimates the risk of unintended harm because only a percentage of positive findings are considered for invasive tissue diagnosis.[39]

The *Summary of the Guidelines Updates* section in the algorithm briefly describes the new changes for the 2020 update. For example, the upper limit of the age cutoff for lung screening has been extended to 77 years (from 74 years) when assessing whether patients are at high risk for lung cancer and therefore are candidates for screening. In addition, the guideline mentions that reporting the presence of CAC detected on chest CT may be useful as a marker of atherosclerosis.[292,293] CAC may be

reported using either a visual score (ie, none, mild, moderate, severe) or a quantitative score (such as the Agatston score).[292] Further evaluation is recommended if CAC is severe.

Lung cancer screening is recommended (category 2A) for group 2 of the high-risk groups who are candidates for lung cancer screening (those ≥50 years with a ≥20 pack-year smoking history and at least one additional risk factor other than second-hand smoke). The NCCN Lung Cancer Screening Panel feels it is important to expand screening beyond the narrow NLST criteria to a larger group of individuals at high risk.[169] Using just the narrow NLST criteria, only 27% of patients currently being diagnosed with lung cancer will be screened. For LDCT of the lung, the preferred slice width is 1.0 mm or less and the acceptable slice width is 2.5 mm or less based on Lung-RADS.

Before recommending lung cancer screening, shared patient/physician decision-making is recommended so that patients have a full understanding of all risks and benefits related to screening with LDCT.[169,373] Shared decision-making aids may assist when determining if screening should be recommended. Smokers should always be advised to quit smoking tobacco (see the NCCN Guidelines for Smoking Cessation, available at www.NCCN.org). Programs using behavioral counseling combined with medications that promote smoking cessation (approved by the FDA) can be very useful. Former smokers should be encouraged to remain abstinent. Multidisciplinary programs (incorporating chest radiology, pulmonary medicine, and thoracic surgery) are recommended to optimize decision-making and minimize interventions for patients with benign lung disease. The USPSTF recommends lung screening; its B recommendation means that lung screening is covered under the Affordable Care Act for individuals with high-risk factors who are 55 to 80 years of age. CMS covers annual screening LDCT for appropriate Medicare beneficiaries at high risk for lung cancer based on the NLST criteria if they also receive counseling and shared decision-making before screening.

Table 1: Comparison of the I-ELCAP and NLST Lung Screening Protocols

Definition of Positive Nodule*	**I-ELCAP**	**NLST†**
Baseline	Solid and PS nodule ≥5 mm‡	Nodule ≥4 mm
	NS nodule ≥8 mm‡	
Annual	New solid or PS nodule	Same as Baseline
	New NS nodule ≥8 mm‡	
Recommendations for Positive Nodule		
Baseline	LDCT in 3 mo, then resume annual LDCT if stable. Consider PET if solid component >10 mm. Biopsy if PET positive; annual LDCT if PET negative. If nodule ≥15 mm, treat with antibiotics and LDCT at 1 mo, or biopsy. LDCT in 1 mo for solid endobronchial nodule.	Solid or PS nodule 4–10 mm, then LDCT 3–6 mo. NS nodule 4–10 mm, then LDCT 6–12 mo. If growth but nodule <7 mm, then LDCT in 3–6 mo. If growth and nodule ≥7 mm, then follow recommendations of nodules >10 mm. Any nodule >10 mm consider biopsy, CECT, PET/CT, or LDCT in 3–6 mo if low suspicion.
Annual	Annual LDCT if NS nodule <8 mm. LDCT in 6 mo if new solid/PS nodule. Antibiotics and 1 mo LDCT if solid/PS nodule ≥5 mm or NS nodule ≥8 mm, then LDCT at 3 mo if nodule stable.	Same as Baseline
Definition of Nodule Growth	≥50% increase in mean diameter if nodule <5 mm	≥10% increase in nodule diameter
	≥30% increase in mean diameter if nodule 5–9 mm	
	≥20% increase in mean diameter if nodule >10 mm	

CECT = contrast-enhanced CT; CT = computed tomography; I-ELCAP = International Early Lung Cancer Action Program; LDCT = low-dose CT;

NLST = National Lung Screening Trial; NS = nonsolid; PET = positron emission tomography; PS = part solid.

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NLST protocol. Available at (https://www.acrin.org/TabID/145/Default.aspx). Accessed May 10, 2019.

*Requiring imaging or workup in addition to annual LDCT. †Guidelines rather than a strict study regimen. ‡Mean diameter of nodule

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