

Screening creates opportunities to detect lung cancer earlier

Detecting lung cancer via screening before symptoms arise may transform it from a fatal disease to a treatable one



Lung cancer is **often diagnosed late** because symptoms are not specific; but at late stages, treatment options are limited.^{1 2}

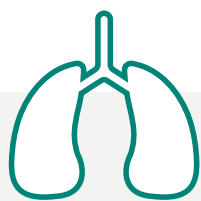


Screening via low-dose computed tomography (LDCT) can **detect lung cancer earlier (stages I and II) and improve survival.**^{3 4}



LDCT screening for lung cancer meets all key targets for screening programmes, including the Wilson and Jungner criteria.^{5 6}

The World Health Organization recognises these criteria as essential for evaluating any new screening programme.⁶



Lung cancer is a significant public health issue

Globally, it accounts for **more than 12% of all cancer cases** and is the leading cause of cancer-related deaths.⁷

Lung cancer has the **greatest economic cost** of all cancers.^{* 8}

* This data point also includes tracheal and bronchial cancers.



There is a detectable early stage of lung cancer, for which effective treatments are available

If diagnosed early (stage I), **five year-survival increases to over 80%**, compared with 7–18% survival when diagnosed late (stage IV).⁹

Detecting lung cancer earlier means people can access **potentially curative and more effective treatment**, such as surgery.^{10 11}



LDCT screening is recognised as a highly effective tool for detecting lung cancer

Targeted LDCT screening **does not lead to a high proportion of unnecessary procedures or treatments.**^{10 12}



Lung cancer screening is cost-effective

LDCT screening is **more efficient** than screening for other types of cancer: fewer people need to be screened to avoid one death from lung cancer.¹³

There is an extensive evidence base supporting the implementation of LDCT screening

References

1. Ruano-Raviña A, Provencio M, Calvo de Juan V, et al. 2020. *ESMO Open* 5(6): e001021
2. Wadowska K, Bil-Lula I, Trembecki Ł, et al. 2020. *Int J Mol Sci* 21(13): 4569
3. Mathew S, Thangavel G, Pujar P, et al. 2025. *Future Oncol* 21(20): 2649–61
4. Amicizia D, Piazza MF, Marchini F, et al. 2023. *Healthcare (Basel)*: 10.3390/healthcare11142085
5. Wilson J, Jungner G. 1968. *Public Health Papers* 34: *Principles and practice of screening for disease*.
6. World Health Organization. 2022. *A short guide to cancer screening: Increase effectiveness, maximize benefits and minimize harms*.
7. Bray F, Laversanne M, Sung H, et al. 2024. *CA Cancer J Clin* 74(3): 229–63
8. Chen S, Cao Z, Prettner K, et al. 2023. *JAMA Oncol* 9(4): 465–72
9. Rami-Porta R, Nishimura KK, Giroux DJ, et al. 2024. *J Thorac Oncol* 19(7): 1007–27
10. Davies MPA, Vulkan D, Gabe R, et al. 2024. *Lancet Reg Health Eur*: 10.1016/j.lanepe.2024.100936
11. Lawrenson R, Lao C, Brown L, et al. 2020. *BMC Cancer* 20(1): 109
12. Paci E, Puliti D, Lopes Pegna A, et al. 2017. *Thorax*: 10.1136/thoraxjnl-2016-209825
13. Wait S, Alvarez-Rosete A, Osama T, et al. 2022. *JTO Clin Res Rep* 3(5): 100329

Scan to access the other factsheets in this series



networksecretariat@hpolicy.com



linkedin.com/company/lung-cancer-policy-network



@LungPolicy



@lungcancerpolicynetwork



**LUNG CANCER
POLICY NETWORK**