BC CANCER LUNG SCREENING
Provincial Health Services Authority

BC Cancer Lung Screening
2024 Program Results

Lung Screening Program Data Extraction Date: August 12, 2026

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MESSAGE FROM DIRECTORS

Message from the Medical Director and Screening Operations Director

In the second full year of operation, the screening program continues to see excellent uptake through the support of primary care providers. The lung cancer detection rate of 1.69% and favorable stage distribution (72% early stage) are similar to the previous year.

The Lung Screening Program would like to thank its partners who have supported and contributed to the Program over the years. The success of the Program depends on an integrated system of:

- Community health professionals promoting the benefits of screening
- Dedicated and highly trained staff to perform and interpret the screening LDCTs
- Primary care providers and medical specialists to provide diagnostic follow-up and treatment
- Health Authority screening centres and diagnostic facilities providing space and personnel to support lung screening LDCTs and the relevant follow-up tests.

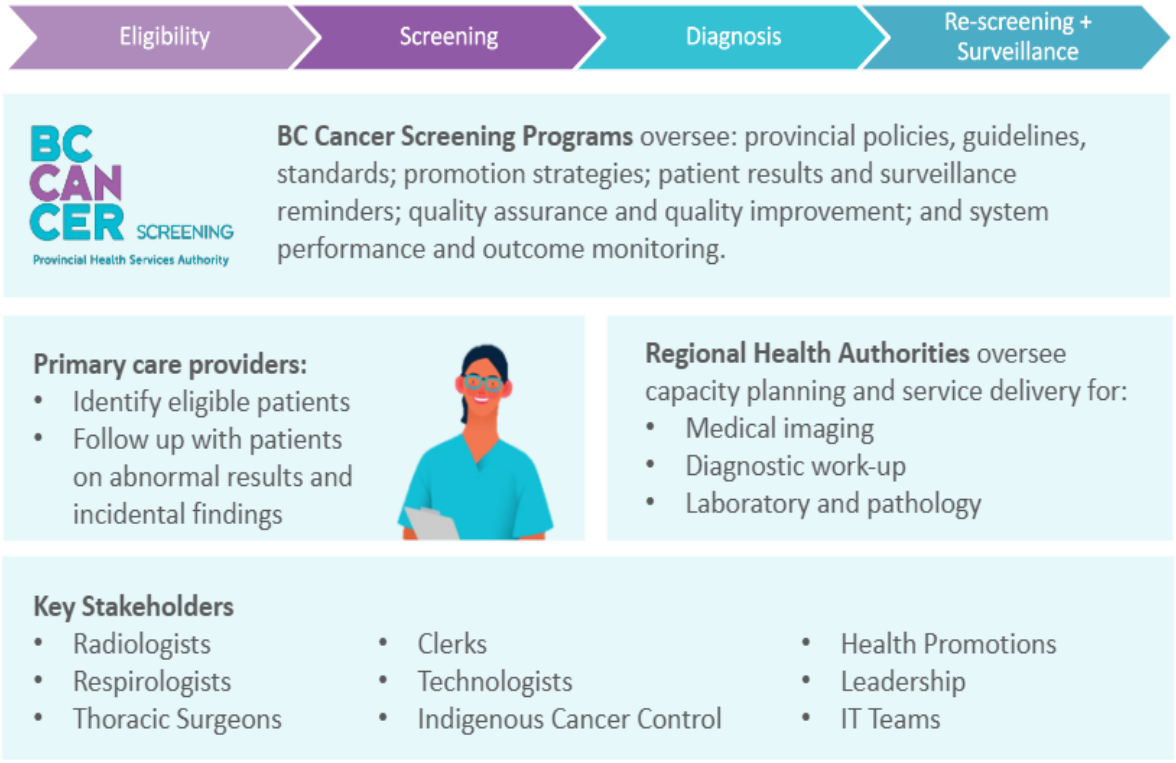
We would like to thank the following organizations for their ongoing support (alphabetical):

- BC Cancer Foundation
- BC Radiological Society
- Canadian Cancer Society
- Canadian Partnership Against Cancer
- College of Physicians and Surgeons of BC
- Doctors of BC
- UBC Division of Family Practice
- Society of General Practitioners

Dr. Stephen Lam, MD, FRCPC and Rableen Nagra, MA

PROGRAM WORKFLOW

FIGURE 1: OVERVIEW OF THE COLLABORATIVE ONGOING EFFORTS MADE WITH KEY PARTNERS

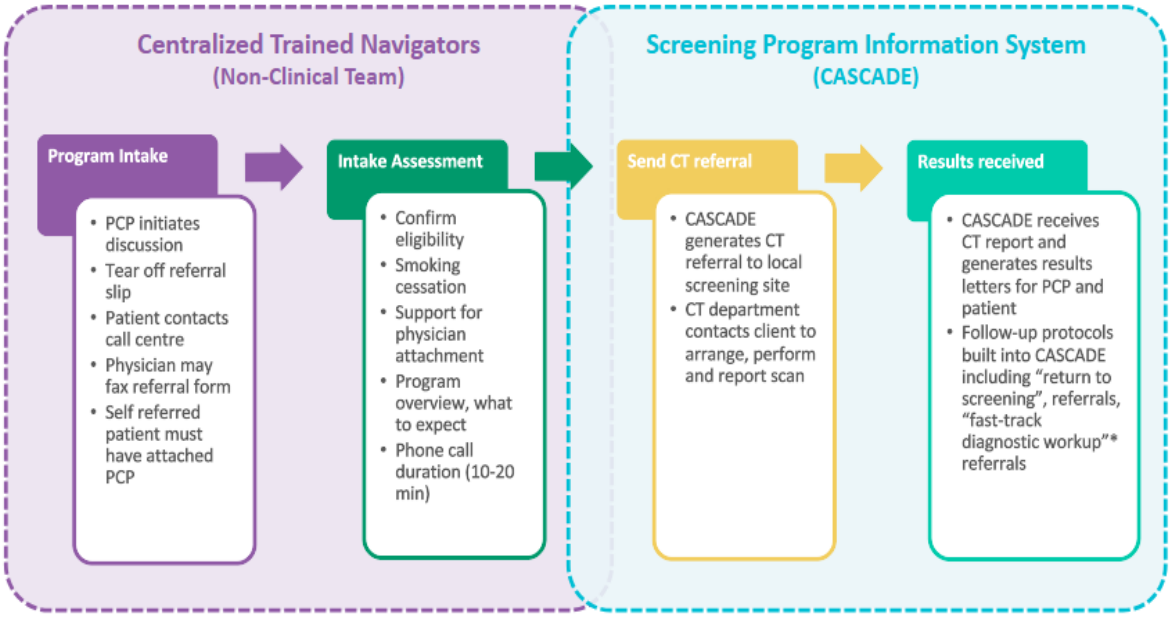


Screening Workflow

The lung screening pathway consists of six stages:

1. **Program Intake**: Primary screening population identified and referred to the Program (either through PCP or self-referral).
2. **Intake Assessment**: Individual must meet eligibility criteria.
3. **LDCT Referral**: Eligible individual receives a screening LDCT scan.
4. **Results Distribution**: Participant and their PCP receive results notices from Program.
5. **Facilitated Diagnostic Referral**: Participant with abnormal screen result is referred to a diagnostic facility for follow-up procedures and investigation; referral is facilitated by Program on behalf of participant's PCP. There is no need for the participant to visit their PCP for a referral.
6. **Retention**: Screening reminder issued at appropriate interval; returning participant must meet eligibility criteria to continue with screening.

FIGURE 2: LUNG SCREENING WORKFLOW



*Screening Program initiates fast-track referral to a designated diagnostic team

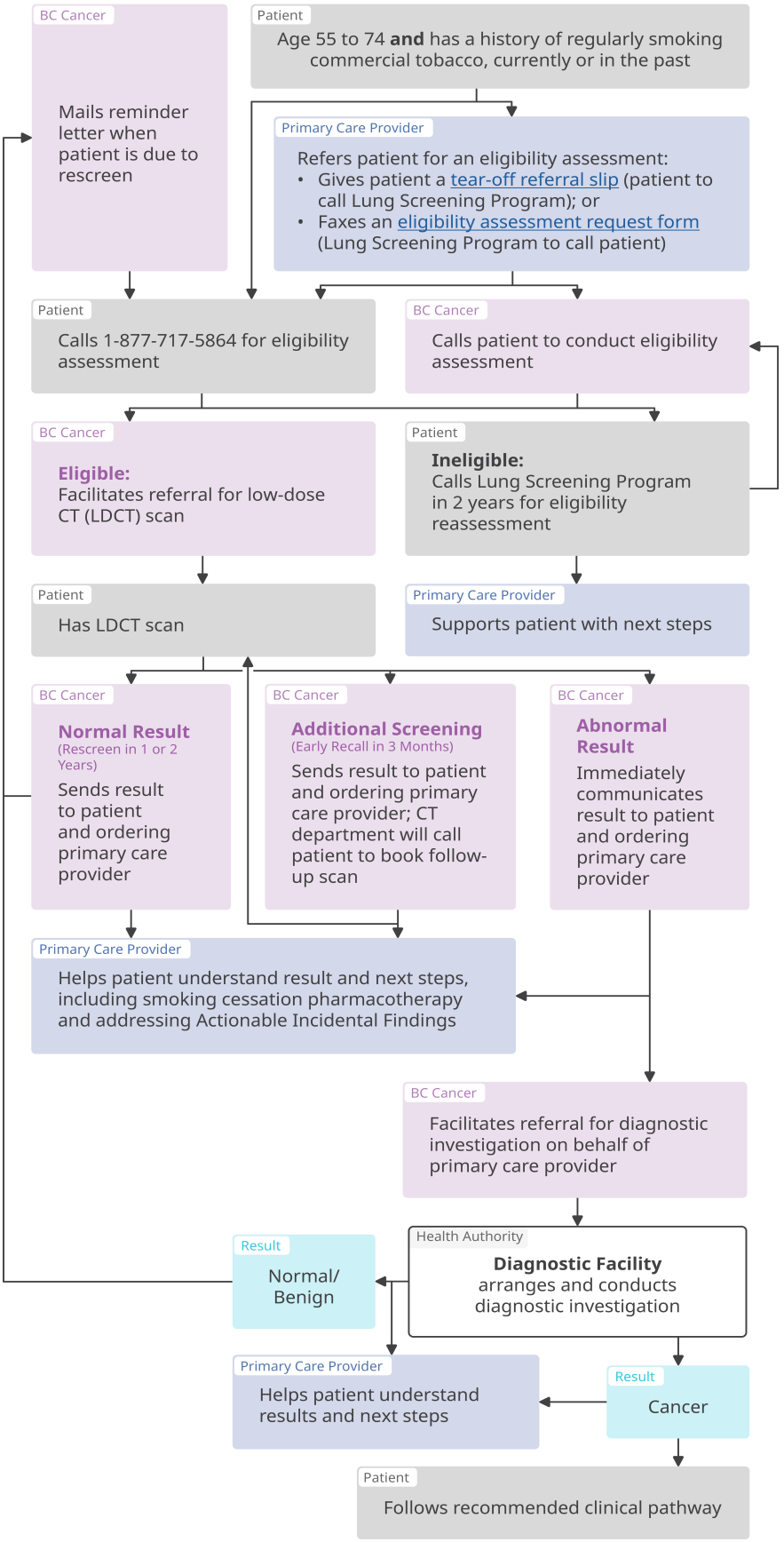
"FAST TRACK" - Facilitated referral to diagnostic imaging for work-up of lesions suspicious for lung cancer

On average, approximately 3% of participants will require a referral to a respirologist and or a thoracic surgeon for diagnostic work-up and about half of them will require a biopsy procedure. The Program facilitates a fast track referral on behalf of their PCPs who will be asked to forward relevant medical history to the diagnostic work-up team. The term "Fast Track" refers to the reduced time it takes for a referral to be sent to a diagnostic work-up team; there is no need for the screening participant to visit their PCP after an abnormal result to receive a requisition as the referral is facilitated by the Program.

Fast Track Process Overview

- At the time of screening, participants are informed that if further tests are required, they will be contacted directly to book their appointment
- If further testing is required, a referral is sent to a Fast Track diagnostic facility to arrange the work-up
- The Program notifies the participant's PCP of the results and where their patient has been referred for additional testing
- The diagnostic facility makes every effort to provide an appointment within two weeks of receiving the referral
- Standardization of the Fast Track referral system ensures that all participants benefit from the shortened time between an initial abnormal screening result and the first appointment for diagnostic assessment

FIGURE 3: LUNG SCREENING PATHWAY



1. Quality Assurance

CT Scanners and Image Acquisition Protocol

The health authority medical physicists conduct annual quality assurance (QA) testing on all CT scanners that are used in lung screening to ensure scanner settings are optimal and can produce high quality images and accurate measurements of nodules.

The Program has supplied each health authority with a Quantitative Imaging Biomarkers Alliance (QIBA) CTLX1 Phantom unit to be used in testing and calibration of scanners. Accumetra, LLC, the QA testing partner who created the Phantom, provides recommended kernel reconstruction settings for different brands and models of scanners. The Phantom tests verify that images are high resolution, and that the measurements performed on all lung screening CT scans are accurate throughout the full field of view: in the centre and periphery of the lungs. Medical physicists conduct tests annually with each scanner using the Phantom unit. The test images are evaluated by Accumetra who produces a report showing pass or fail on aspects such as 3D spatial resolution, 3D reconstruction slice thickness, noise, and spatial warping based on the images. Reports are sent to the Program for tracking.

Screening Radiologist Standards

Prior to reading and reporting screening LDCTs for the Program, program radiologists are required to review training modules:

1. Nodule Types, Measurement and Documentation
2. Management Recommendation and Standardized Reporting of Screen Detected Lung Nodules
3. Reporting of Incidental Findings

Following in-service training for the AI computer-assisted reporting tool, a radiologist must report 11 test cases. The reports are reviewed by the Program Medical Imaging Lead and Program Medical Director. Once all training and testing have been completed, the radiologist will then become a program screener.

A multi-disciplinary case review is conducted quarterly to examine difficult cases and exchange knowledge on LDCT interpretation and management recommendation.

Annually, each program screener receives a screening statistics report highlighting key metrics to guide practice optimization. Metrics include annual screen volume, normal vs abnormal call rate, and cancer detection rate.

2. Regular Promotion and Education Activities

The Health Promotion team regularly promotes the Lung Screening Program through a series of outreach strategies tailored to the intended screening population/public and primary care providers.

Ongoing promotion activities include:

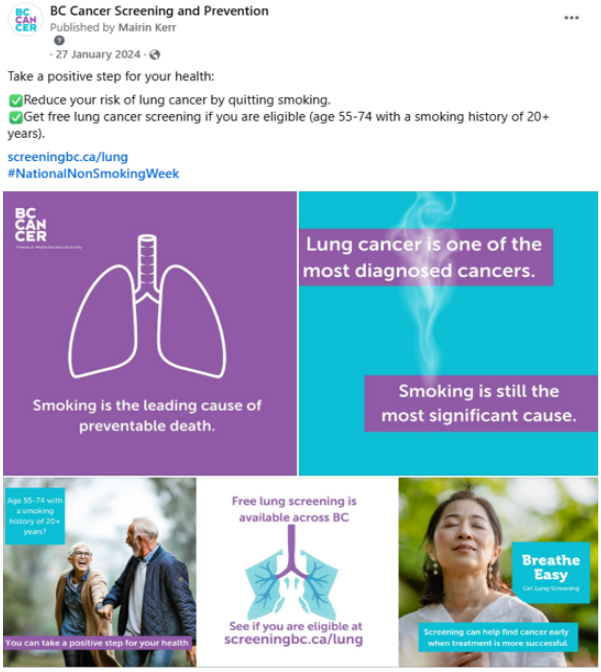
- Promotional tools, such as brochures, posters, marketing giveaways, bookmarks and postcards that effectively communicate the benefits of lung screening;
- Media advertisements to promote lung screening;
- A "@BCCancer" Instagram account that promotes relevant information about cancer screening including facts about lung screening and eligibility criteria;
- A Facebook page (@BCCancerScreeningandPrevention that promotes relevant information about lung screening and an open platform for information sharing;
- A website (www.screeningbc.ca/lung) to support informed decision-making about lung screening.

In 2024, additional activities included:

- Sharing information and answering questions about the Lung Screening Program at health care provider events. Inquiries from primary care provider attendees about the eligibility criteria, how to referring the most-likely eligible patients, and how to manage patients' expectations about the assessment process, provide valuable feedback to the Program to review the smoking history criteria, clarify the guidelines and explore opportunities to build providers' knowledge to assess patient eligibility for lung screening.
- Facilitating 8 workshops (with a total of 259 participants) and attending 93 days of community events (ranging from health expos and craft fairs to food banks and workplace wellness initiatives) to educate the public about the four screening programs, including lung screening and sharing lung screening resources. Highlights from these events included:
    - o The public were curious to learn about the Lung Screening Program, especially eligibility and how LDCT screening works;
    - o Brochures and postcards were often taken by people to give to loved ones as a gentle reminder to consider getting screened.
- Celebrating Lung Cancer Awareness Month in November by promoting information and patient stories on social media.

FIGURE 4: PHOTOS FROM LUNG SCREENING COMMUNITY ENGAGEMENT WORKSHOPS AND EVENTS

FIGURE 5: LUNG SCREENING SOCIAL MEDIA POSTS



PROGRAM RESULTS

Program Evaluation Data is collected and analyzed on an ongoing basis to monitor the Program's effectiveness and to identify areas for improvement. Lung Screening Program performance indicators, quality standards and systems evaluation are based on national and international guidelines and recommendations. Age-specific lung cancer incidence and mortality rates are provided by the BC Cancer Registry.

This section provides outcomes for various indicators including coverage, participation, follow-up, quality of screening, detection, and disease extent at diagnosis. The indicators used are adapted from the Canadian Partnership Against Cancer guidelines (Lung Cancer Screening Indicators: Data Specifications. July 2024).

1. Program Uptake

Key highlights

- Of all candidates aged 55 to 74 who underwent eligibility intake assessments in 2024, 95% were either directly referred or recommended to participate in screening by their PCP; the remaining candidates found out about lung screening through friends and family, the BC Cancer website, advertisements, or social media.
- Of the total assessed, 80% were found eligible and referred to a screening centre for a screening LDCT scan, and 86% of this group received their scan.
- Average age of eligible participants is around 65 years of age.
- 54% of them have high school education or less, a proxy for lower socioeconomic status.
- Average smoking prevalence rate at the time of assessment was 56%.

TABLE 1: ELIGIBILITY ASSESSMENT BREAKDOWN

	Intake Assessment	Return Assessment	Total
Total Individuals Assessed	**8,497**	**2,771**	**11,268**
Provider-referred	8,104 (95%)	NA	**NA**
Self-referred	393 (5%)	NA	**NA**
Total Individuals Eligible	**6,315 (74%)**	**2,707 (98%)**	**9,022 (80%)**
Average Age	65 years	66 years	**65 years**
High School Education or Less	56%	49%	**54%**
Smoking at Assessment Time	60%	47%	**56%**
Total Individuals Screened[1]	**5,254 (83%)**	**2,485 (92%)**	**7,739 (86%)**

[1] *Individuals who received a routine LDCT scan within 6 months after being deemed eligible at risk assessment*

Breakdown	Eligible	BC Population
Indigenous	**8%**	2%
Non-Indigenous	**92%**	98%
Male	**55%**	48%
Female	**45%**	52%

Table 2 show the **eligibility rate:** (the percentage of BC individuals assessed and deemed eligible to receive a LDCT scan) by sex, age, and geography.

TABLE 2: ELIGIBILITY RATE

	Assessed	Eligible
All	11,268	**9,022 (80%)**
By Sex		
Female	5,142	**4,045 (79%)**
Male	6,124	**4,975 (81%)**
Other	2	**2 (100%)**
By Age		
55-59	1,945	**1,190 (61%)**
60-64	3,164	**2,479 (78%)**
65-69	3,594	**3,049 (85%)**
70-74	2,565	**2,304 (90%)**
By Geography		
Urban	9,105	**7,252 (80%)**
Rural	2,090	**1,712 (82%)**
Unknown	73	**58 (79%)**

Screen Rate: (the percentage of BC individuals who were eligible for lung screening and received at least one screening LDCT scan within 3 months and within 6 months after risk assessment) by sex, age, health area of the referring facility and geography is presented in Table 3.

TABLE 3: SCREEN RATE 2024

	Eligible	Screened within 3 months	Screened within 6 months
All	9,022	6,880 (76%)	**7,739 (86%)**
By Sex			
Female	4,045	3,052 (75%)	**3,446 (85%)**
Male	4,975	3,826 (77%)	**4,291 (86%)**
Other	2	2 (100%)	**2 (100%)**
By Age			
55-59	1,190	872 (73%)	**998 (84%)**
60-64	2,479	1,873 (76%)	**2,092 (84%)**
65-69	3,049	2,330 (76%)	**2,625 (86%)**
70-74	2,304	1,805 (78%)	**2,024 (88%)**
By Health Area			
Fraser Health	1,900	1,466 (77%)	**1,746 (92%)**
Interior Health	2,599	2,334 (90%)	**2,457 (95%)**
Island Health	2,108	1,310 (62%)	**1,680 (80%)**
Northern Health	736	685 (93%)	**707 (96%)**
Vancouver Coastal Health	1,218	1,079 (89%)	**1,138 (93%)**
Unknown	461	6 (1%)	**11 (2%)**
By Geography			
Urban	7,252	5,449 (75%)	**6,175 (85%)**
Rural	1,712	1,386 (81%)	**1,513 (88%)**
Unknown	58	45 (78%)	**51 (88%)**

Retention Rate: is the percentage of BC individuals who were recommended for an annual routine screen in 2023 or a biennial routine screen between May 1st 2022 and December 31st 2022 and completed a subsequent LDCT scan by end of 2024[1]. Table 4 summarizes the retention rate by sex, age, and geography in 2024.

TABLE 4: RETENTION RATE 2024[2]

	Recommended Annual Screen	Subsequent Screen Completed	Recommended Biennial Screen	Subsequent Screen Completed
All	1,140	**907 (80%)**	1,256	**930 (74%)**
By Sex				
Female	545	**441 (81%)**	533	**397 (74%)**
Male	595	**466 (78%)**	722	**532 (74%)**
Other			1	**1 (100%)**
By Age				
55-59	130	**99 (76%)**	190	**147 (77%)**
60-64	289	**221 (76%)**	364	**304 (84%)**
65-69	401	**334 (83%)**	408	**330 (81%)**
70-74	320	**253 (79%)**	294	**149 (51%)**
By Geography				
Urban	943	**763 (81%)**	996	**747 (75%)**
Rural	192	**140 (73%)**	257	**182 (71%)**
Unknown	5	**4 (80%)**	3	**1 (33%)**

[1] *Subsequent scan completed within 1-month pre- and 6-month post-recommended screening due date*
[2] *Individuals who developed lung cancer, were deceased, moved out of BC, or were deemed ineligible at return assessment were removed from the count of individuals recommended for annual or biennial screening*

Of individuals who reported smoking at previous assessment, the percentage who reported having quit smoking since previous screening assessment, reported as the **Smoking Abstinence Rate**, is presented in Table 5.

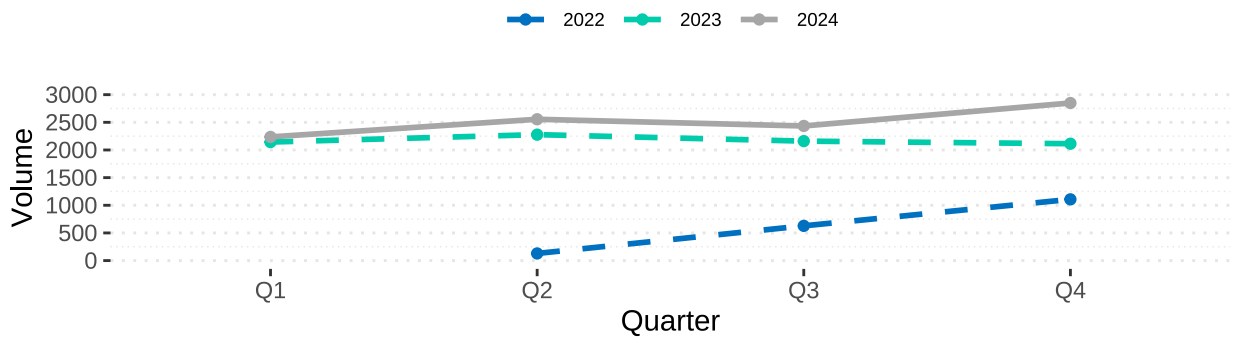
TABLE 5: SMOKING ABSTINENCE RATE

	Smoking at Previous Screening Assessment	Quit Smoking at Subsequent Screening Assessment
All	1,092	**196 (18%)**
By Sex		
Female	557	**98 (18%)**
Male	535	**98 (18%)**
Other	0	
By Age		
55-59	118	**17 (14%)**
60-64	321	**57 (18%)**
65-69	389	**76 (20%)**
70-74	264	**46 (17%)**
By Screen Type		
Return to Screen 1-year	646	**102 (16%)**
Return to Screen 2-years	446	**94 (21%)**
By Geography		
Urban	904	**163 (18%)**
Rural	183	**33 (18%)**
Unknown	5	**0 (0%)**

2. Screening Volume

The Program performed 10,074 LDCT scans in this year.

FIGURE 6: SCREENING VOLUME BY YEAR



The screen types are defined as:

- **Baseline**: first reported screen
- **Early Recall**: follow-up screen recommended for 3-months after last LDCT (surveillance)
- **Return to Screen 1-year**: subsequent routine screen recommended for 1 year after last LDCT (low risk)
- **Return to Screen 2-years**[1]: subsequent routine screen recommended for 2 years after last LDCT (very low risk)

FIGURE 7: SCREENING VOLUME BY SCREEN TYPE[2]

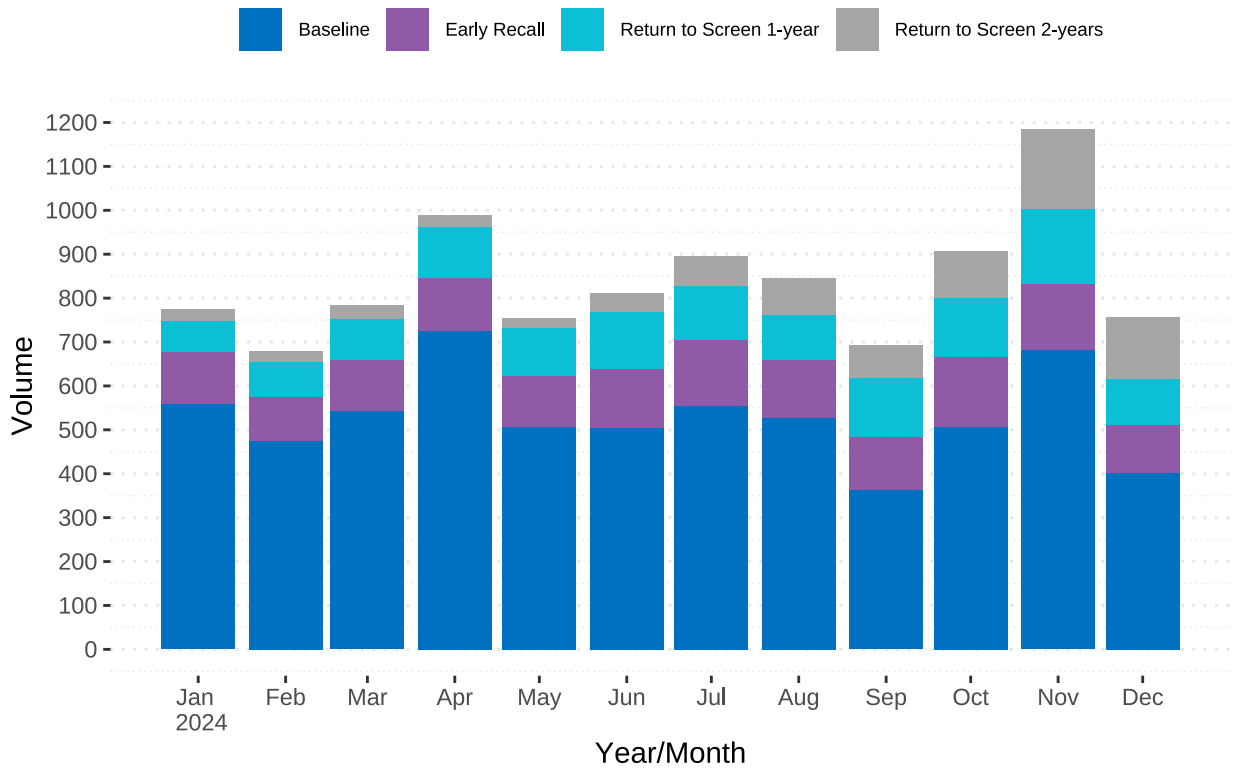


TABLE 6: SCREENING VOLUME BY SCREEN TYPE[2]

Screen Type	2022	2023	2024
Baseline	1,736 (93.1%)	6,785 (78.1%)	6,352 (63.1%)
Early Recall	78 (4.2%)	1,059 (12.2%)	1,518 (15.1%)
Return to Screen 1-year	7 (0.4%)	300 (3.5%)	1,376 (13.7%)
Return to Screen 2-years	43 (2.3%)	549 (6.3%)	828 (8.2%)
Total	**1,864**	**8,693**	**10,074**

[1] *Includes participants that rolled into the Program from the Lung Screening Trials*
[2] *Volume represents total LDCT scans (baseline, routine annual and biennial screens, and early recalls) completed on the total eligible*

FIGURE 8: SCREENING VOLUME BY HEALTH AREA[1]

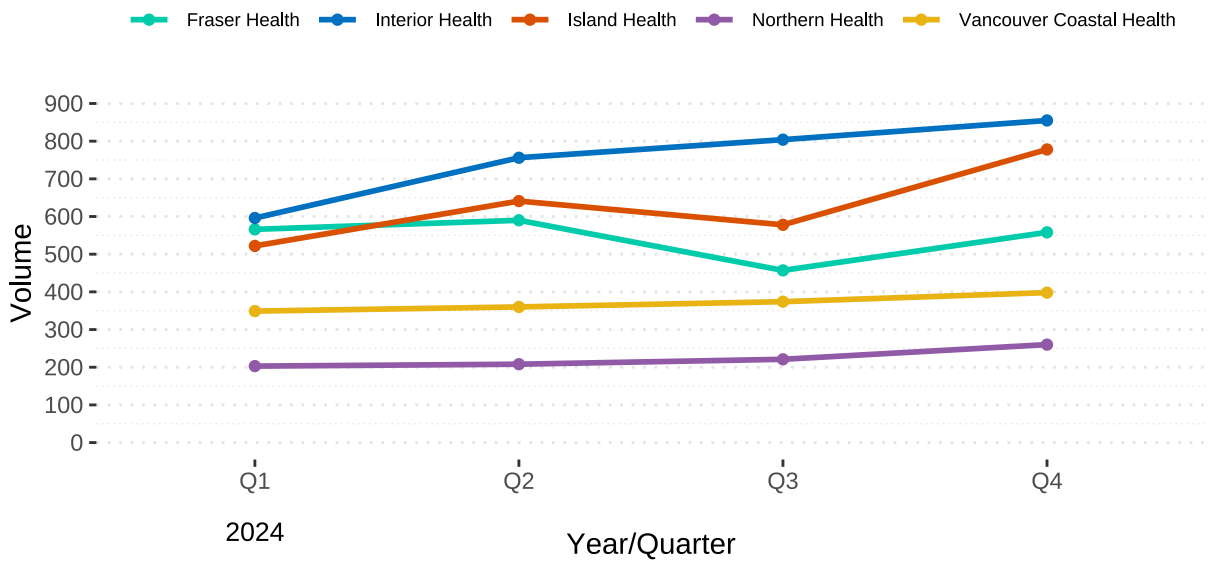


TABLE 7: SCREENING VOLUME BY HEALTH AREA[1]

Health Area	2024
Fraser Health	2,171
Interior Health	3,011
Island Health	2,519
Northern Health	892
Vancouver Coastal Health	1,481
Total	**10,074**

[1] *Volume represents total LDCT scans (baseline, routine annual and biennial screens, early recalls, and post diagnostic) completed on the total eligible*

3. Individual LDCT Outcomes

The possible reported outcomes after an LDCT scan are:

- **Normal**: Routine LDCT scan recommended
  - o ***No Concerning Findings***: Biennial Routine (Return to Screen in 2-years)
  - o ***Low Chance of Cancer***: Annual Routine (Return to Screen in 1-year)
- **Additional Screening Required**: Scan shows findings that may be related to inflammation, infection or a need to monitor an area more closely
  - o **Early Recall**: Return to Screen in 3 months. Following a baseline LDCT, approximately 15% of participants require an early recall LDCT for findings mostly related to infection or inflammation with a small chance of malignancy. The Program facilitates early recall referrals on behalf of PCPs for their patients who require monitoring.
- **Abnormal/Suspicious**: A nodule(s) requires further investigation
  - o **Follow-up Required**: Diagnostic work-up recommended which may include more scans or a biopsy

TABLE 8: INDIVIDUAL LDCT OUTCOME[1]

		Test Outcomes Breakdown			
	Total Screened	**Biennial Routine**	**Annual Routine**	**Early Recall**	**Follow-up Required**
All	8,362	4,608 (55%)	2,273 (27%)	1,213 (15%)	268 (3%)
By Sex					
Female	3,714	1,864 (50%)	1,090 (29%)	612 (16%)	148 (4%)
Male	4,647	2,744 (59%)	1,183 (25%)	600 (13%)	120 (3%)
Other	1			1 (100%)	
By Age					
55-59	1,023	643 (63%)	236 (23%)	124 (12%)	20 (2%)
60-64	2,293	1,369 (60%)	555 (24%)	304 (13%)	65 (3%)
65-69	2,849	1,542 (54%)	788 (28%)	428 (15%)	91 (3%)
70-74	2,197	1,054 (48%)	694 (32%)	357 (16%)	92 (4%)
By Screen Type					
Baseline	6,243	3,951 (63%)	1,108 (18%)	978 (16%)	206 (3%)
Return to Screen 1-year	1,273	137 (11%)	935 (73%)	150 (12%)	51 (4%)
Return to Screen 2-years	846	520 (61%)	230 (27%)	85 (10%)	11 (1%)
By Geography					
Urban	6,752	3,690 (55%)	1,890 (28%)	955 (14%)	217 (3%)
Rural	1,569	898 (57%)	375 (24%)	246 (16%)	50 (3%)
Unknown	41	20 (49%)	8 (20%)	12 (29%)	1 (2%)

[1] *This indicator excludes early recall LDCT scans because they are considered as under surveillance rather than routine screens.*

Invasive Procedures Rate is the percentage of individuals who received an invasive procedure within 3 months following a routine LDCT scan. Table 9 presents this rate by sex, age, screen type, and geography.

TABLE 9: INVASIVE PROCEDURES WITHIN 3 MONTHS OF A ROUTINE LDCT

	Participants Screened	Follow-up Required	Received Invasive Procedure
All	8,362	268	**140 (2%)**
By Sex			
Female	3,714	148	**81 (2%)**
Male	4,647	120	**59 (1%)**
Other	1	0	**0 (0%)**
By Age			
55-59	1,023	20	**14 (1%)**
60-64	2,293	65	**24 (1%)**
65-69	2,849	91	**48 (2%)**
70-74	2,197	92	**54 (2%)**
By Screen			
Initial	6,244	206	**112 (2%)**
Subsequent	2,118	62	**28 (1%)**
By Screen Type			
Baseline	6,243	206	**112 (2%)**
Return to Screen 1-year	1,273	51	**24 (2%)**
Return to Screen 2-years	846	11	**4 (0%)**
By Geography			
Urban	6,752	217	**110 (2%)**
Rural	1,569	50	**30 (2%)**
Unknown	41	1	**0 (0%)**

Table 10 presents the **Cancer Detection Rate** (the number of lung cancers detected per 1,000 screened participants) based on sex, age, screen type, and geography.

TABLE 10: CANCER DETECTION RATE

		Cancer diagnosis by months after LDCT scan (count and rate per 1,000)				
	Participants Screened	**≤3 Months**	**3–6 Months**	**6–12 Months**	**>12 Months**	**Total**
All	8,362	87 (10.4)	37 (4.4)	16 (1.9)	2 (0.2)	**142 (17.0)**
By Sex						
Female	3,714	51 (13.7)	24 (6.5)	10 (2.7)	0 (0.0)	**85 (22.9)**
Male	4,647	36 (7.7)	13 (2.8)	6 (1.3)	2 (0.4)	**57 (12.3)**
Other	1	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	**0 (0.0)**
By Age						
55-59	1,023	4 (3.9)	1 (1.0)	1 (1.0)	1 (1.0)	**7 (6.8)**
60-64	2,293	20 (8.7)	13 (5.7)	2 (0.9)	0 (0.0)	**35 (15.3)**
65-69	2,849	28 (9.8)	14 (4.9)	5 (1.8)	0 (0.0)	**47 (16.5)**
70-74	2,197	35 (15.9)	9 (4.1)	8 (3.6)	1 (0.5)	**53 (24.1)**
By Screen						
Initial	6,244	68 (10.9)	25 (4.0)	11 (1.8)	1 (0.2)	**105 (16.8)**
Subsequent	2,118	19 (9.0)	12 (5.7)	5 (2.4)	1 (0.5)	**37 (17.5)**
By Screen Type						
Baseline	6,243	68 (10.9)	25 (4.0)	11 (1.8)	1 (0.2)	**105 (16.8)**
Return to Screen 1-year	1,273	16 (12.6)	11 (8.6)	5 (3.9)	1 (0.8)	**33 (25.9)**
Return to Screen 2-years	846	3 (3.5)	1 (1.2)	0 (0.0)	0 (0.0)	**4 (4.7)**
By Geography						
Urban	6,752	69 (10.2)	30 (4.4)	13 (1.9)	2 (0.3)	**114 (16.9)**
Rural	1,569	18 (11.5)	7 (4.5)	3 (1.9)	0 (0.0)	**28 (17.8)**
Unknown	41	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	**0 (0.0)**

The **Positive Predictive Value (PPV)** represents the percentage of individuals with an abnormal LDCT result who were diagnosed with lung cancer after completion of diagnostic work-up. Table 11 summarizes the PPV by sex, age, screen type, and geography.

TABLE 11: POSITIVE PREDICTIVE VALUE

			Cancer Type		
	Diagnostic Work-ups	**Cancer Diagnosis**	**Small Cell**	**Non-small Cell**	**Positive Predictive Value (%)**
All	268	142	8	134	**53.0**
By Sex					
Female	148	85	4	81	**57.4**
Male	120	57	4	53	**47.5**
Other	0	0	0	0	**0.0**
By Age					
55-59	20	7	2	5	**35.0**
60-64	65	35	1	34	**53.8**
65-69	91	47	3	44	**51.6**
70-74	92	53	2	51	**57.6**
By Screen					
Initial	206	105	5	100	**51.0**
Subsequent	62	37	3	34	**59.7**
By Screen Type					
Baseline	206	105	5	100	**51.0**
Return to Screen 1-year	51	33	1	32	**64.7**
Return to Screen 2-years	11	4	2	2	**36.4**
By Geography					
Urban	217	114	8	106	**52.5**
Rural	50	28	0	28	**56.0**
Unknown	1	0	0	0	**0.0**

Table 12 summarizes the **Stage Distribution** of non-small cell lung cancers that were detected. The stage classification according to TNM reference[1].

TABLE 12: STAGE DISTRIBUTION OF DETECTED NON-SMALL CELL LUNG CANCERS

		Stage				
	Non-small Cell Cancer	**0**	**I**	**II**	**III**	**IV**
All	134	0 (0%)	81 (60%)	17 (13%)	22 (16%)	14 (10%)
By Sex						
Female	81	0 (0%)	54 (67%)	10 (12%)	9 (11%)	8 (10%)
Male	53	0 (0%)	27 (51%)	7 (13%)	13 (25%)	6 (11%)
Other	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
By Age						
55-59	5	0 (0%)	4 (80%)	0 (0%)	0 (0%)	1 (20%)
60-64	34	0 (0%)	21 (62%)	4 (12%)	4 (12%)	5 (15%)
65-69	44	0 (0%)	27 (61%)	9 (20%)	5 (11%)	3 (7%)
70-74	51	0 (0%)	29 (57%)	4 (8%)	13 (25%)	5 (10%)
By Screen						
Initial	100	0 (0%)	53 (53%)	15 (15%)	19 (19%)	13 (13%)
Subsequent	34	0 (0%)	28 (82%)	2 (6%)	3 (9%)	1 (3%)
By Screen Type						
Baseline	100	0 (0%)	53 (53%)	15 (15%)	19 (19%)	13 (13%)
Return to Screen 1-year	32	0 (0%)	27 (84%)	2 (6%)	3 (9%)	0 (0%)
Return to Screen 2-years	2	0 (0%)	1 (50%)	0 (0%)	0 (0%)	1 (50%)
By Geography						
Urban	106	0 (0%)	63 (59%)	12 (11%)	17 (16%)	14 (13%)
Rural	28	0 (0%)	18 (64%)	5 (18%)	5 (18%)	0 (0%)
Unknown	0	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

[1]Rami-Porta R, Nishimura KK, Giroux DJ, Detterbeck F, et al. ; Members of the IASLC Staging and Prognostic Factors Committee and of the Advisory Boards, and Participating Institutions. The International Association for the Study of Lung Cancer Lung Cancer Staging Project: Proposals for Revision of the TNM Stage Groups in the Forthcoming (Ninth) Edition of the TNM Classification for Lung Cancer. J Thorac Oncol. 2024 Jul;19(7):1007-1027. doi: 10.1016/j.jtho.2024.02.011. Epub 2024 Mar 4. PMID: 38447919.

Wait Time for Definitive Diagnosis is defined as the weeks between the date of an abnormal LDCT scan and the date of a pathologically and/or cytologically confirmed diagnosis within 6 months. Figure 9 and Table 13 show the wait time for definitive diagnosis by geography. The target is 12 weeks (red dotted line).

FIGURE 9: WAIT TIME FOR DEFINITIVE DIAGNOSIS

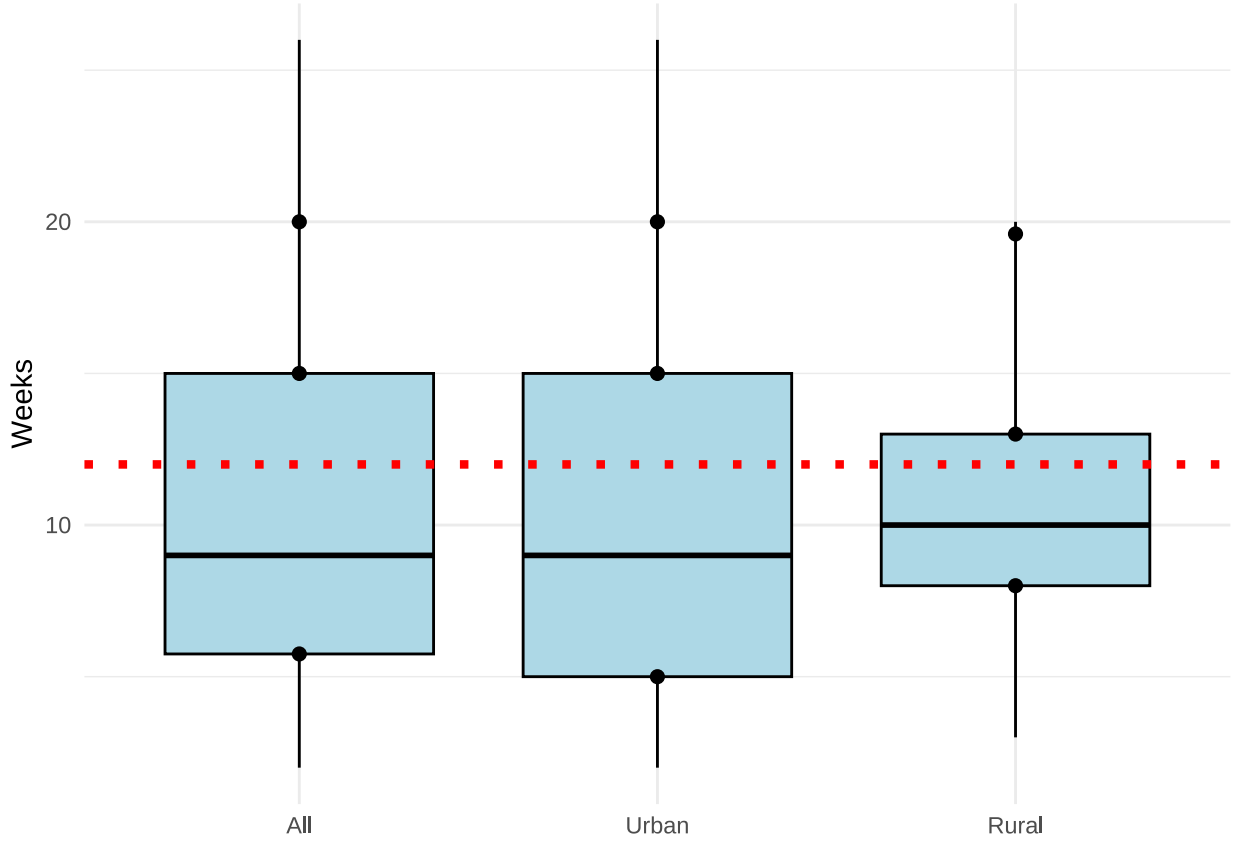
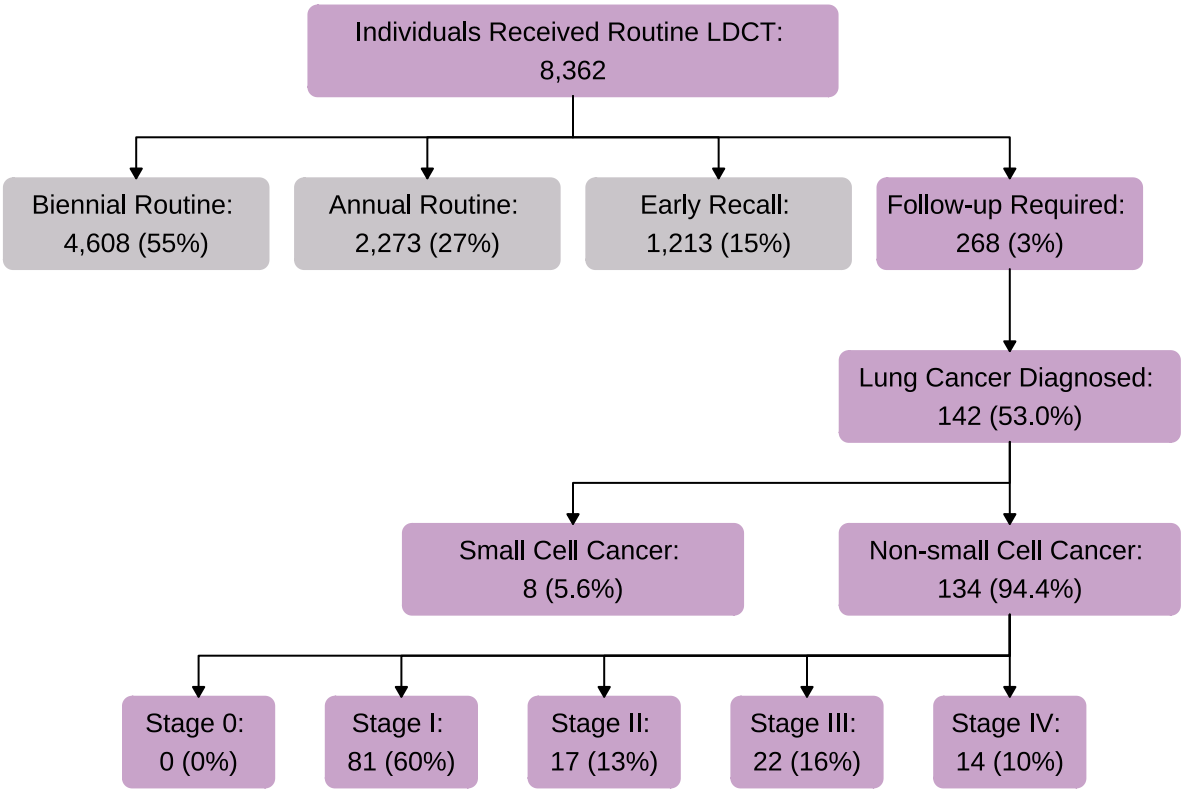


TABLE 13: WAIT TIME FOR DEFINITIVE DIAGNOSIS OF LUNG CANCER[1]

	Cancer Diagnosis > 6 months[2]	Cancer Diagnosis ≤ 6 months[3]	Median (weeks)	90th percentile (weeks)
All	18	124	9	20
By Geography				
Urban	15	99	9	20
Rural	3	25	10	20
Unknown	0	0		

[1] *This indicator reports a different lung cancer count compared to other indicators because it requires a six-month time frame between screening and diagnosis in its calculation*
[2] *The number of lung cancer cases with a definitive diagnosis wait time exceeding six months*
[3] *The number of lung cancer cases with a definitive diagnosis wait time of six months or less*

FIGURE 10: SCREENING OUTCOME SUMMARY 2024



APPENDICES

1. Glossary

Eligibility Rate

Percentage of BC individuals assessed and deemed eligible to receive a LDCT scan

$$\text{Eligibility Rate} = \frac{\text{Individuals eligible for LDCT scan}}{\text{Individuals assessed}} \times 100$$

Screen Rate

Percentage of BC individuals who were eligible for lung screening and received at least one screening LDCT scan

$$\text{Screen Rate} = \frac{\text{Individuals completed at least one LDCT scan}}{\text{Individuals eligible for LDCT scan}} \times 100$$

Retention Rate

Percentage of BC individuals who were recommended for an annual/biennial routine screen in the measurement timeframe and completed a subsequent LDCT scan within the recommended scan interval

$$\text{Retention Rate} = \frac{\text{Individuals completed a subsequent LDCT scan}}{\text{Individuals recommended for an annual/biennial routine screen}} \times 100$$

Smoking Abstinence Rate

Percentage of individuals who reported having quit smoking since previous screening assessment

$$\text{Smoking Abstinence Rate} = \frac{\text{Individuals who reported having quit smoking}}{\text{Individuals who reported smoking}} \times 100$$

Invasive Prodecures Rate

Percentage of individuals who received an invasive procedure within 3 months following a routine LDCT scan

$$\text{Invasive Prodecures Rate} = \frac{\text{Individuals who received an invasive procedure}}{\text{Individuals who had a routine LDCT scan}} \times 100$$

Cancer Detection Rate

The number of lung cancers detected per 1,000 screened participants

$$\text{Cancer Detection Rate} = \frac{\text{Individuals diagnosed with lung cancer}}{\text{Individuals completed a routine LDCT scan}} \times 1{,}000$$

Positive Predictive Value

Percentage of individuals with an abnormal LDCT result who were diagnosed with lung cancer after completion of diagnostic work-up

$$\text{Positive Predictive Value} = \frac{\text{Individuals diagnosed with lung cancer}}{\text{Individuals with an abnormal LDCT result}} \times 100$$

2. Publications and Presentations

a) Publications

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b) Presentations

Stephen Lam

- New York Lung Cancer Foundation Summit – Lung Cancer Screening. Current Status. March 14, 2024, New York
- IASLC CT Symposium, CT Screening In Canada: Lessons Learned. San Diego, September 7, 2024.
- G7 Working Group – Cancer Prevention Webinar: Lung Cancer Screening in G7 countries: Challenges and Lessons learned. Canada's perspective. Virtual. October 10, 2024.
- MD Anderson Cancer Center Cancer Prevention and Control Grand Rounds. Houston, Texas, USA. Progress in lung cancer interception. November 15, 2024.
- Canadian Cancer Society Lung Cancer Summit/ Innovations in Lung Cancer Care. Toronto. November 28, 2024.

Rableen Nagra and Stephen Lam

Canadian Partnership Against Cancer Lung Cancer Screening Network Meeting:

- Shared decision making tool Guidance and Content Development Workshop. Feb 13, and April 8, 2024
- KTE event: Integrating smoking cessation into lung cancer screening programs. June 26, 2024
- Lung Cancer implementation. September 26, 2024

3. Lung Screening Program / BC Cancer Contact Information (alphabetical by surname)

Dr. Stephen Lam
Lung Screening Medical Director
Phone: 604-675-8094
Email: slam@bccancer.bc.ca

Dr. Mayo John
Lung Screening Imaging Director
Phone:604-875-4111
Email: John.Mayo@vch.ca

Rableen Nagra, MA
Screening Operations Director, Breast and Lung Screening
Phone: 604-877-6000 ext 4845
Email: rableen.nagra@bccancer.bc.ca

Screening Programs Administration Office
801 – 686 West Broadway, Vancouver, B.C. V5Z 1G1
Phone: 604-877-6200
Fax: 604-660-3645
Website: www.bccancer.bc.ca/screening/lung
Email: Screeningadmin@bccancer.bc.ca