in other locations around the world, and intrigued by multiple possibilities to further expand it. ■

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Teresa Bruni, M.D.
Università Cattolica del Sacro Cuore
Roma, Italy
and
Imperial College London
London, United Kingdom

Ajit Lalvani, M.A., D.M., F.R.C.P., F.Med.Sci., F.F.P.H.
Imperial College London
London, United Kingdom

Luca Richeldi, M.D., Ph.D.*
Università Cattolica del Sacro Cuore
Roma, Italy

ORCID IDs: 0000-0003-0199-8629 (T.B.); 0000-0002-2396-246X (A.L.); 0000-0001-8594-1448 (L.R.).

*Corresponding author (e-mail: luca.richeldi@policlinicogemelli.it).

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Improving Lung Cancer Screening Uptake

To the Editor:

The recent article by Quaife and colleagues (1) and the accompanying editorial by Burnett-Hartman and Wiener (2) report the results of the LSUT (Lung Screen Uptake Trial) from London and provide comments from Boston. The trial is important because it provides evidence that there may be ways to improve the dismal uptake of lung cancer screening, especially in higher-risk, underserved populations. The editorialists point out some differences between the United Kingdom and United States, including the important fact that patient contact came from the individual primary care physician, which is in contrast to the approach used in the United States, where many patients do not have an identifiable primary care physician. There are other important factors, including the emphasis on the "Lung Health Check" rather than on more narrow lung cancer screening and the absence of copays or other financial disincentives for computed tomographic scans in the United Kingdom compared with the United States. In PLuSS (Pittsburgh Lung Screening Study) (3), we have also emphasized total lung health by providing annual spirometry, and we have eliminated financial barriers by waving all copays. We have also been using the electronic health record to identify potential candidates for lung screening. As our ability to obtain more information from the low-dose computed tomographic scans by radiomic advances, we hopefully can rebrand lung cancer screening in the United States, maybe as heart and lung screening, to facilitate more widespread use. ■

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David O. Wilson, M.D., M.P.H.*
University of Pittsburgh Medical Center
Pittsburgh, Pennsylvania

ORCID ID: 0000-0002-2635-7468 (D.O.W.).

*Corresponding author (e-mail: wilsondo@upmc.edu).

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Reply to Wilson

From the Authors:

We read Wilson's response letter to both our LSUT (Lung Screen Uptake Trial) (1) and the accompanying editorial by Burnett-Hartman and Wiener (2) with great interest and value the insightful discussion they raise. Together we share in the challenge of achieving both equitable *and informed* uptake of low-dose computed tomography lung cancer screening by high-risk individuals, but the differences between the United Kingdom and United States that Wilson raises are important for how we intervene. The United Kingdom benefits from a coordinated and universal primary care system, and we appreciate that sending postal invitations directly from the individual's primary care physician is a strategy that may not translate

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