All right. Good afternoon, everyone.

We’re going to go ahead and get started here. It’s my pleasure to introduce Doctor Herman Pogosian. She’s an associate professor at Yale University School of Nursing. She received her Bachelor of Science in nursing from Jonkoping University in Sweden, and she received her PhD from the American University of Armenia and her PhD from the University of Massachusetts, Boston. Doctor Pogosian completed a postdoctoral
fellowship and interprofessional health services research at the Betty Irene Moore School of Nursing. At the University of California, Davis. Her research focus is on cancer epidemiology and survivorship research with a particular interest in cancer health disparities, lung cancer screening survivors and their social network members including families, friends and others. Doctor proposing is the principal investigator of an NCI funded R1 that is investigating social networks and effective states in the context of smoking behaviors among adults.
00:00:57.710 --> 00:01:00.370 diagnosed with tobacco related cancer.

00:01:00.370 --> 00:01:02.183 Please join me in welcoming Dr Prozium

00:01:02.183 --> 00:01:03.990 to Yale Cancer Center grand rounds.

00:01:03.990 --> 00:01:04.570 Thank you.

00:01:09.160 --> 00:01:12.714 Thank you. Good afternoon everyone and

00:01:12.714 --> 00:01:15.630 thank you Michael for the kind introduction.

00:01:15.630 --> 00:01:18.142 And I’m very excited to be here today

00:01:18.142 --> 00:01:21.070 and to share some of my work with you.

00:01:21.070 --> 00:01:23.606 And I’ll be talking a little bit about

00:01:23.606 --> 00:01:26.323 lung cancer screening in the US and also

00:01:26.323 --> 00:01:29.070 tobacco use among cancer survivors.

00:01:29.070 --> 00:01:32.150 So just to give a little bit

00:01:32.150 --> 00:01:34.770 of a background information,

00:01:34.770 --> 00:01:38.674 we know that lung cancer is the 2nd

00:01:38.674 --> 00:01:42.347 leading cause of cancer and the leading.
00:01:42.350 --> 00:01:44.510 Leading cause of cancer related death
NOTE Confidence: 0.9702219
00:01:44.510 --> 00:01:47.390 in the US in both men and women,
NOTE Confidence: 0.9702219
00:01:47.390 --> 00:01:50.477 and this year it is estimated that
NOTE Confidence: 0.9702219
00:01:50.477 --> 00:01:53.648 there will be about 236,000 new
NOTE Confidence: 0.9702219
00:01:53.648 --> 00:01:57.405 lung cancer cases and about 130,000
NOTE Confidence: 0.9702219
00:01:57.405 --> 00:02:00.870 deaths from lung cancer.
NOTE Confidence: 0.9702219
00:02:00.870 --> 00:02:03.957 But when we look at the incidence and the
NOTE Confidence: 0.9702219
00:02:03.957 --> 00:02:07.078 mortality rates for lung cancer by race,
NOTE Confidence: 0.9702219
00:02:07.078 --> 00:02:10.848 certain racial and ethnic minorities groups,
NOTE Confidence: 0.9702219
00:02:10.848 --> 00:02:14.551 they suffer more from lung cancer and
NOTE Confidence: 0.9702219
00:02:14.551 --> 00:02:17.730 they have worse clinical outcomes
NOTE Confidence: 0.9702219
00:02:17.730 --> 00:02:20.290 compared to white individuals.
NOTE Confidence: 0.9702219
00:02:20.290 --> 00:02:21.736 And in fact,
NOTE Confidence: 0.9702219
00:02:21.736 --> 00:02:24.628 African American men have the highest
NOTE Confidence: 0.9702219
00:02:24.628 --> 00:02:27.871 rate of lung cancer incidence rate
and the highest mortality rate.

Compared to other racial ethnic groups and just for example one of the studies, our earlier study that we published in general thoracic oncology, we found that black patients who had got surgery for their lung cancer, they had much lower post operative mental health related quality of life compared to white patients undergoing lung cancer surgery. And also in terms of survival like there is again significant difference in a five year survival comparing. Racial ethnic minority groups...
00:03:11.724 --> 00:03:13.317 with white individuals,
NOTE Confidence: 0.9702219
00:03:13.320 --> 00:03:14.704 the five year survival.
NOTE Confidence: 0.9702219
00:03:14.704 --> 00:03:16.434 The overall five year survival.
NOTE Confidence: 0.9702219
00:03:16.440 --> 00:03:20.388 All stages combined is.
NOTE Confidence: 0.9702219
00:03:20.390 --> 00:03:23.259 Among all the races is 22% but when
NOTE Confidence: 0.9702219
00:03:23.259 --> 00:03:25.797 you compare the black individuals have
NOTE Confidence: 0.9702219
00:03:25.797 --> 00:03:28.465 much have lower five year survival
NOTE Confidence: 0.9702219
00:03:28.465 --> 00:03:31.750 from lung cancer compared white and
NOTE Confidence: 0.9702219
00:03:31.750 --> 00:03:35.642 lung cancer has has a poor prognosis.
NOTE Confidence: 0.9702219
00:03:35.642 --> 00:03:39.057 And early detection of lung cancer is
NOTE Confidence: 0.9702219
00:03:39.057 --> 00:03:42.228 kind of the key to improve survival
NOTE Confidence: 0.9702219
00:03:42.228 --> 00:03:45.529 among patients diagnosed with lung cancer.
NOTE Confidence: 0.9702219
00:03:45.530 --> 00:03:48.206 And unfortunately a lot of work
NOTE Confidence: 0.9702219
00:03:48.206 --> 00:03:50.500 has been done showing that.
NOTE Confidence: 0.9702219
00:03:50.500 --> 00:03:51.838 The early diet,
NOTE Confidence: 0.9702219
00:03:51.838 --> 00:03:55.300 the only less than 20% of patients are
00:03:55.300 --> 00:03:57.760 diagnosed with early stage lung cancer.

00:03:57.760 --> 00:04:00.308 Some of the studies suggest even like 16%,

00:04:00.308 --> 00:04:02.516 around 16% are diagnosed with stage

00:04:02.516 --> 00:04:05.374 one lung cancer when the more curative

00:04:05.374 --> 00:04:07.058 treatment options are available

00:04:07.058 --> 00:04:09.618 that help to improve the survival

00:04:09.618 --> 00:04:11.979 among these patients and last kind

00:04:11.979 --> 00:04:15.320 of 10 years or so about the sodium.

00:04:17.340 --> 00:04:19.716 Screening for lung cancer with low

00:04:19.716 --> 00:04:21.768 dose computed tomography has been

00:04:21.768 --> 00:04:24.144 shown to reduce lung cancer mortality

00:04:24.144 --> 00:04:26.160 among individuals at higher risk,

00:04:26.160 --> 00:04:27.696 so one of them well known.

00:04:27.700 --> 00:04:30.524 The study conducted in trial in the US

00:04:30.524 --> 00:04:32.670 national lung cancer screening trial
showed that screening with low dose computed tomographic decreases lung cancer rate mortality rate by 20% and another study recently that came out more recently Nelson study trial. And from Netherlands, they showed that up to 26% reduction in lung cancer mortality among those who got screened for lung cancer with low dose computed tomography. So the and then since 2013, we have a guideline in place by US Preventive Service Task Force recommending annual lung cancer screening for high risk individuals. And those individuals are asymptomatic.
adults ages 50 to 80 years old and current and former smokers who quit within the past 15 years and they have at least 20 pack years of smoking history. So this guideline was updated last year before the March 2021. The age range age started 55 years to 80 years old and then the Smoking Pack history was 30 pack year history. So they decreased last year the the guideline the criteria of 20 pack year sister instead of 30 and 20 pack year sister means that someone smokes at least one pack of cigarettes per day for at least 20 years.
And Centers for Medicare and Medicaid Services provides coverage for annual lung cancer screening with low dose computer tomography for eligible individuals. And Affordable Care acts mandate private insurance companies to cover lung cancer screening. So one of the main one of the main reason that the screening guideline was updated the decrease the age and decrease the smoking. Great because? A lot of work has been done showing that black individuals were less often eligible under that guideline for lung cancer screening despite
they have developing lung cancer at much younger age and they have a lower smoking intensity. So it was hard to meet at least 30 pack years of smoking, and also they have like when you look at the smoking prevalence comparing non-Hispanic whites and non-Hispanic blacks. They have kind of a little bit like similar smoking rates, but they have much higher blocking incidence rate from lung cancer, mortality rate from lung cancer.
They are diagnosed with much earlier age and they have a lower in smoking intensity compared to white.

So that’s why they expanded the kind of change the criteria with the hope that that more racial and ethnic minorities group will meet.

Lung cancer screening criteria, so become eligible.

And with that, with the earlier guideline, the about studies show that about 8,000,000 adults were eligible for lung cancer.

With a new guideline about 14.5 million adults are eligible for lung cancer. And there have been studies showing
that when they changed the guidelines just few came out that more like with the new eligibility criteria, higher proper high proportion of African Americans meet. Lucky meets the criteria for lung cancer screening. So. The current rate for lung cancer screening is very low. The utilization, the uptake of lung cancer screening is very low in the US the new report that came out about in 2019 was 6.6% and then 2020 it dropped a little bit to 6.5%,
but there have been some studies done and also our work that showed a little bit higher rate. So that’s so, but this the new report showed much lower rate. That’s why I just wanted to bring to bring this numbers here and a lot of work has been done to show that lung cancer screening rate uptake is much lower among African American individuals or Russian ethnic minorities compared to white minorities. But the guy since guideline changed last March,
there’s still a lot of work need to be done to kind of have that clear understanding of the lung cancer screening uptake by race, ethnicity and there has been. Reports show saying that estimating that if we implement national lung cancer screening we could prevent up to like 6000 deaths in the US so but unfortunately the uptake is very low. So we are interested in this study. So since some work has been done to show like uptake is low and then the uptake specifically it is much lower among racial and ethnic minorities.
So we were interested to conduct this study to understand the intention of high risk individuals to get screened for the lung cancer if their primary care provider recommended it so specifically.

In this study, we investigated the association between worry about future health issues of smoking and intention to undergo recommended lung cancer screening with low dose computed tomography within the next three months when the healthcare provider recommended it.
This was a cross-sectional survey who conducted the online survey. We used Qualtrics research panel to recruit study subjects. In this study we included 152 adults aged between 55 to 74 years old with at least 30 pack years of smoking. So this was part of a much larger study we had that we looked into electronic cigarette use as well and the total sample size of the original study was eight. And out of 800 twenty 152 who made the criteria of at least having 30 pack years of smoking.
So we used 30 pack years of smoking because of the prior guideline for lung cancer screening and the age range we used 55 to 74 based on the national lung cancer screening eligible eligibility criteria. The outcome variable was the intention to undergo lung cancer screening with low dose computed tomography within the next three months if healthcare provider recommended it and the predictive was the worry about health consequences of smoking. It also collected some covered It also collected some covered, coverage as well. We used Stata to conduct descriptive
statistics and logistic regression,
so this table shows sample characteristics.

Majority of them were about 80%
were ages between 55 to 64 years
and about 60% were male.

We oversampled a racial and ethnic
minoritized individuals in our sample.

So about 21.7% self reported as black
individuals and 42.8% self reported
minoritized individuals in our sample.

We are Hispanics.

And we had like 25% of the sample.

We are Hispanics.

In terms of the income,
kind of a little bigger portion of
00:12:31.779 --> 00:12:35.676 the participants 36.8% had the lower
NOTE Confidence: 0.857130374285714
00:12:35.676 --> 00:12:39.356 than 25,000 annual household income.
NOTE Confidence: 0.90803731
00:12:42.300 --> 00:12:45.832 So we found that majority
NOTE Confidence: 0.90803731
00:12:45.832 --> 00:12:48.966 of the samples about 86.2%,
NOTE Confidence: 0.90803731
00:12:48.966 --> 00:12:51.196 they’re willing to undergo lung
NOTE Confidence: 0.90803731
00:12:51.196 --> 00:12:52.980 cancer screening if healthcare
NOTE Confidence: 0.90803731
00:12:53.052 --> 00:12:54.800 provider recommended it so.
NOTE Confidence: 0.90803731
00:12:54.800 --> 00:12:59.260 And also found that 67.7%
NOTE Confidence: 0.90803731
00:12:59.260 --> 00:13:01.980 were very much worried,
NOTE Confidence: 0.90803731
00:13:01.980 --> 00:13:03.516 moderately or very much
NOTE Confidence: 0.90803731
00:13:03.516 --> 00:13:05.052 worried about them smoking
NOTE Confidence: 0.90803731
00:13:05.052 --> 00:13:06.650 related health consequences.
NOTE Confidence: 0.826208976111111
00:13:08.720 --> 00:13:12.493 So in this this table shows the
NOTE Confidence: 0.826208976111111
00:13:12.493 --> 00:13:15.148 participants smoking history and the
NOTE Confidence: 0.826208976111111
00:13:15.148 --> 00:13:17.980 mean pug years tobacco smoking was
NOTE Confidence: 0.826208976111111
00:13:17.980 --> 00:13:20.115 50.8 and the mean number of years

they’ve been smoking cigarette was

So in the regression analysis, we found that, you know, high individuals, who were moderately or very much worried about the health consequences of smoking, are much more willing to undergo recommended lung cancer screening. We didn’t find difference by age groups and but we also found that men had much higher odds of reporting willingness to undergo lung cancer. Training if they were recommended by their healthcare provider compared to female and also the interesting
finding where the black individuals, those self reported black individuals at high risk for developing lung cancer. They had much lower odds ratio of reporting, the screening by race, ethnicity, African self reported black individuals have much lower odds of being willing to get screened.
and I think like that.

So this was a quantitative study,

one of the steps will be I think.

To conduct kind of qualitative

study just to understand why they
don’t want to get screened.

So with this only we know that yes the

percentage is lower and they don’t want.

But I think that we need kind of to

go more in depth to understand like

why they don’t want to get this life

saving screening and we should have

like a public health initiative to

increase awareness of lung cancer

screening among specifically among.
Racial and ethnic minorities groups, and there has been some other studies showing that the awarenesses public among general population about lung cancer screening is quite low.

So we should do some public health initiatives to increase that awarenesses. So one of the interesting thing for the for getting screened for lung cancer is the sheer decision making visits. So CMS mandates that healthcare providers have to have a shared decision screening visit with with patients then refer them to lung cancer screening. So during that visit healthcare providers need to identify if the patient is eligible
00:16:19.376 --> 00:16:21.870 for screening based on their age and.
00:16:21.870 --> 00:16:24.936 Smoking history and they also need
00:16:24.936 --> 00:16:27.634 to discuss about benefits and the
00:16:27.634 --> 00:16:29.574 risks of lung cancer screening.
00:16:29.580 --> 00:16:31.652 They need to use your decision making
00:16:31.652 --> 00:16:33.970 aid that talks about risks and benefits
00:16:33.970 --> 00:16:36.022 of lung cancer screening and during
00:16:36.079 --> 00:16:38.074 that visit they also need to discuss
00:16:38.074 --> 00:16:40.094 about that if with current smokers
00:16:40.094 --> 00:16:42.422 they need to discuss emphasize the
00:16:42.422 --> 00:16:44.184 importance of quitting smoking and
00:16:44.184 --> 00:16:46.158 if those who are former smokers,
00:16:46.160 --> 00:16:48.386 they need to discuss the importance
00:16:48.386 --> 00:16:50.770 of being existent from from smoking.
00:16:50.770 --> 00:16:51.757 So we conducted.
NOTE Confidence: 0.882909251
And I use this study to understand like just rate of patient provider discussion about lung cancer screening is it happening or not happening and then to understand how it is related to. Quite attempts so specifically in this study invested in investigated the relationship between patient provider discussions about lung cancer screening and smoking quit attempts among adults eligible for lung cancer screening.

So I used this data from that main study that I mentioned earlier, like 821 subjects. Out of them, 282 met the criteria of at least
20 pack years of smoking history.

So outcome variable was the quit attempt.

They tried to quit smoking within the past 12 months.

And for the predictor variable, participants were asked the question at any time in the past year.

Have you talked with your doctor or other health professional about having a test to check for lung cancer.

So this is the sample characteristics again.

So majority were between 55 to 64 years of age female 62% and 26% were identified as self identified black individuals,
18% self identified Asian individuals and 37% white individuals.

And in terms of lung cancer screening it was kind of surprising to see that much. Majority of them 84% did not have discussion with their healthcare provider about lung cancer screening. Even if even though they were at much higher risk for developing lung cancer screening because we use a 20 pack years the criteria to include study subjects. Only 16% reported that they discussed.
So this table shows participants smoking history and about the mean pack year of tobacco use was 39.4 and the mean number of years they smoked cigarette was 44.4 and majority of the participants. 59% of the participants had at least 30 or more pack year smoking history and 39% of the participants they tried to quit smoking. In the past year we also asked participant what methods they used to help them to quit smoking and the surprisingly a lot of them reported. Switching to electronic cigarette, will help them to quit smoking.
But we know from the later evidence that that's not the case. It’s it. It doesn’t help individuals to quit smoking and stay existence successfully for a longer time. And so in the regression analysis we found that those who had discussion with their healthcare providers about lung cancer screening, they’re much more likely to try to quit smoking compared to those who did not have discussion we didn’t find. I didn’t find the differences by race or ethnicity, and also didn’t find the differences.
in them in the having.
Non cancerous discussion would healthcare providers by race and or or ethnicity.
So, so one of the the main finding of many individuals who are eligible for lung cancer screening, they don’t do, they don’t get, they have to have the shared decision making and also.
And the one the some other
research shows that improving,
providing education training for healthcare providers about lung cancer screening kind of will help to improve the lung cancer uptake. So the having the discussion with patients about lung cancer screening it kind of it helps to kind of improve the lung cancer screening uptake as well as it will improve, it will help patients to get motivated. Try to quit smoking and maybe eventually help them to quit smoking. So also another way is then people who get screened, there has been another work.
including our earlier. So those who get actually get to the point to get screened for lung cancer. So they are more motivated to try to quit smoking. So that’s why like this are kind of very much related. So first helping patients to quit smoking or referring them to lung cancer screening. So help them also to to quit smoking. And so one of the other big part of my work has been focused on understanding tobacco use among cancer survivors, and I use the NCI definition for cancer
survivors and individuals are considered cancer survivors from the time of diagnosis through the balance of life and their family members, caregivers, friends are all impacted by the survivorship experience and they’re included. And this definition, so we know that. And do two major advancement in cancer screening or detection and treatment. So many individuals these days live with the history of cancer diagnosis. In fact, in 1971 about 3,000,000 individuals who live in cancer history. And as of January this year about 18 million individuals are living with cancer history and it is projected
to increase significantly by 2014.

There will be about 26 million cancer survivors.

So in order to maximize the overall well-being of this growing population of cancer survivors, identifying the health risk behaviors and helping them to change will help improve their overall well-being.

And one of the health risk behaviors is tobacco use, which is still prevalent among individuals diagnosed with cancer even though a lot of work has been done.
over the past five decades.

Still, many individuals continue to smoke after the cancer diagnosis,
and the prevalence of the tobacco use varies by cancer type. And those who are diagnosed with the tobacco related cancer, they have the highest rate of smoking compared to those who are not diagnosed with tobacco related cancers. And we know that continued tobacco use reduces the cancer treatment effectiveness and it worsens treatment side effects, reduces overall survival.
It also increases the risk of recurrence and symptom burden and also. Increases the risk of smoking related comorbidities and we know that there are, there is a. Evidence based tobacco treatment guidelines available in the US and that healthcare provider that would help health healthcare providers to use that to follow that guideline to help individuals smokers to quit smoking. So the gold standard for tobacco treatment is using combining the use of pharmacotherapy and behavioral
intervention and healthcare.

First they need to assess and document tobacco use, then provide advice to quit those who smoke, and then assist them with their pharmacotherapy and behavioral counseling. And they also own a regular basis. They have to reassess smoking status among former smokers to make sure they are still absent from tobacco use. And then we conducted this study so to understand how cancer programs are implementing this evidence based tobacco treatments. So we conduct in this study we know
00:26:02.045 --> 00:26:04.781 that from other work that tobacco use still is prevalent among individuals diagnosed with cancer.

00:26:04.781 --> 00:26:10.280 So in this study we just wanted to understand more like how this evidence based.

00:26:13.552 --> 00:26:16.802 Michael, Guideline is implemented and then the results we found that only 7% of those Cancer programs in the Northeast region, they had optimal integration of the guidelines into their delivery system and only about 39% of this program had a system in place that healthcare providers can easily identify screen for.
tobacco use and then document the
NOTE Confidence: 0.845404635555556
also only 25% they had.
NOTE Confidence: 0.845404635555556
System in place that they could easily
NOTE Confidence: 0.845404635555556
deliver pharmacotherapy and refer
NOTE Confidence: 0.845404635555556
them to a counseling so and so all
NOTE Confidence: 0.845404635555556
found that the tobacco treatments
NOTE Confidence: 0.845404635555556
were not delivered consistently
NOTE Confidence: 0.845404635555556
and routinely among cancer
NOTE Confidence: 0.845404635555556
survivors so and one of the some
NOTE Confidence: 0.845404635555556
of the Bears identified in the.
NOTE Confidence: 0.845404635555556
Oh, identified in the work related
NOTE Confidence: 0.845404635555556
to not having the optimal strategy in
NOTE Confidence: 0.845404635555556
place to identify to screen for tobacco
NOTE Confidence: 0.845404635555556
use and document a lot of providers.
NOTE Confidence: 0.845404635555556
They reported the limited time,
NOTE Confidence: 0.845404635555556
so they didn’t have enough time
to screen for that as well. And then. Limited reimbursement for clinicians to provide tobacco treatment was also another barrier. So NCI identifies as well like that the screening for tobacco use, documenting tobacco use and treating is kind of has and hasn’t been that well in the in this country and since in 2017 is NCI launched Cancer Center cessation initiative which was funded part of the NCI Cancer Moonshine Program and the overall like. Long term goal of this.
Of this initiative is that to provide funding to cancer centers and to help them build and implement sustainable tobacco cessation treatment programs that can help healthcare providers routinely address tobacco sensation among cancer survivors. Since 2017, fifty-two NCI designated cancer centers have received this funding. Studies have shown positive outcomes for those centers that received the funding. There is a system in place to identify and document tobacco use among cancer survivors.
and help smokers to quit smoking, but it’s been since 2017 so like I think sustainability should be evaluated so for longer term to see if it’s still moving on. From my work and from the work of other researchers kind of we understand how the we know that tobacco use is still is a problem is still. And common among individuals were diagnosed with lung individuals who had cancer. So we decided to conduct this study and it was funded by NCI to understand the role of social networks and
affective States and in smoking behavior among cancer patients.

So I have done some work looking at the role of social networks and I'm sure you know like the Yale has a big team who looks at the social network as well. It really shows how important it is to involve your social network members to help to change the smoking behavior or health risk behaviors.

But when you look at the intervention side like smoking cessation programs, those are mostly focused on an individual and we know that those if they get a treatment get the referral. But when they go back home,
like get the treatment by get home in their network and someone is in the network smoking it increases their chance of like starting smoking. So that's why so we discount, we are hoping, hoping that we can develop social network best smoking cessation interventions for patients diagnosed with tobacco related cancers. So hopefully we can help them to quit smoking and stay quit for a longer term. So on this grant I am working with them. Team then if I have like really great team, excellent collaborators from
Dana Farber Cancer Institute, Northeastern University and Dartmouth College and I have a consultants from MGH and University of Pennsylvania, we just started the recruitment. So this is the specific aims. Basically we want to understand how they impact the smoking behavior of cancer population and also we want to know that how the cancer diagnosis impacts on the social network members, the role of social network members, how they impact the smoking behavior of cancer population and also we want to know that how the cancer diagnosis impacts on the social network members, smoking behavior. So I have done some work to look into the the cancer diagnosis that it kind of motivates network members to
change their health risk behaviors.

So this is a mixed method design.

The phase one we’re conducting it’s a quantitative approach.

We’re using egocentric social network approach to identify tobacco late,

hence individual stagnant with tobacco related cancer and then after the phase one date it’s a one year follow up and we’ll we’re conducting a best line then three months,

six months and 12 months and then after 12.

Months do we want to do a qualitative dieting interviews with the cancer survivor and self identify significant
So we just started a screening, we are recruiting from Dana Farber Cancer Institute and we are. So we have some discussions that maybe later we can open up to the recruitment to include your Cancer Center. As well. So this is just the illustration of the egocentric social network. So basically all information, the ego here represents the individual diagnosis tobacco related cancer and then network members.
they are who they identify.

So, so far actually it’s going well

collecting the social network data is quite rich and so we are doing via zoom,

so our program manager. Michael?

Research coordinator, they meet via zoom,

so we collect the data via zoom

and so far it’s been great and

we’ll see how it’s going to be.

Our sample size is 4 point 24129,

so hopefully we can reach our sample

size and then to see how the the role of social network in the.
And the smoking behavior.

So this is I would like to thank everyone that helped me to build my program of research and what I did, my education and the team and everyone that I'm working with and if you have any questions I'll be happy to answer. Thank you.

Good.

Questions for Doctor Symposium?

We have at least. OK, go ahead. Thank you.

Do you see a correlation between either willingness to quit or willingness to screen?

I thought that for either your personal studies with the number of pack years,
also with their accuracy with the risk of.

The risk of getting token cancer efficiently.

So thank you. So for the willingness of the

We include everyone with at least

30 pack years, but I didn’t look

We didn’t look at that, but there have been some work that

They look like having the park

here as a continuous variable.

So when it increases,
screen from other researchers work.

But we just didn’t look at that separately.

I actually had a related question to that.

So for those, so in your study, you looked at whether or not a conversation with their provider impacted their willingness or their attempts to quit, correct.

I was wondering if there was any idea to look at actual people who actually received lung cancer screening and then whether or not that then directly
00:36:20.168 --> 00:36:21.720 impacted their willingness to quit.

00:36:21.800 --> 00:36:23.160 So yeah, that’s actually.

00:36:23.160 --> 00:36:25.592 That’s like I have like some research

00:36:25.592 --> 00:36:28.481 project working on like we have to do like

00:36:28.552 --> 00:36:30.944 a longitudinal to see if they get the,

00:36:30.950 --> 00:36:32.450 if they have the referral,

00:36:32.450 --> 00:36:34.620 then the referral,

00:36:34.620 --> 00:36:36.200 if it helps them to quit

00:36:36.200 --> 00:36:38.570 smoking so from other works.

00:36:38.656 --> 00:36:40.826 So that’s all like when I saw the the

00:36:40.830 --> 00:36:43.071 literature review we did people who

00:36:43.071 --> 00:36:45.424 the literature review we did people who

00:36:45.424 --> 00:36:48.247 actually get to that point who get screened,

00:36:48.250 --> 00:36:50.644 they are more likely to be motivated

00:36:50.644 --> 00:36:52.848 and they make quit attempts but

00:36:52.848 --> 00:36:54.369 So that’s actually.
we know that the smoking. Is like just they need to get help. Just trying the quit attempt is a first step but successfully quit they need to get help. So in our study we just looked only the discussion. We didn’t follow up, it was just cross-sectional. We didn’t follow up to see if they actually screened and then if they screened they steal. The quit attempts are higher or lower and also the. I’m in that say I looked on the use the criteria, updated criteria 20 pack years.
So one of the explanation can be such a low rate of discussion that healthcare providers they didn’t know that the guideline would be changed. So I looked at 20 but the study collected 2017 so. It might have been lower, so if the guideline was updated earlier. So we have a question from the chat from Doctor Silver, she asked under resource, patients poor as well as ethnic and racial minoritized groups are more likely to roll their own cigarettes due to expense and maybe under.
counted when it comes to pack years.

Any thoughts about trying to capture those who do not bypass?

So yeah, that’s a very important question and that’s a good question.

So yes, that’s another issue.

But in order to Umm the way to measure it, it’s very difficult if they roll their own cigarettes.

So that’s kind of one of the limitation that we’re going to miss those population just healthcare providers, they have to follow whatever CMS mandates.

So first they have to count their tobacco use, then they each and then meet the guidelines so without, so that’s.
The limitation is it will be very hard to identify those people who roll their own cigarettes. So one of the requirements that they have to meet to smoke at least 20 pack years of a cigarette, that’s the history.

OK. Well, I have one. I have one other additional question. This is a pretty big picture one now. So and that first study that you presented you found about 86% of the patients or the participants had reported a willingness to
undergo lung cancer screening. However, like an actual real-world practice, the percentage of people who actually do undergo screening is under 10%, correct. Do you have any thoughts about this disconnect or ways to study it? Or even down the roadways to address it potentially. So yeah, that’s very important. So even though they are Wheeling, there has been a lot of work song, so they meet, they get discussion,
they get referral that they have to
screen and then they don’t show up.
So like that’s why screening rate
is low and I think there would be
like community enrich like programs
or like the patient navigator.
So I think they should be
some system in place that we can follow up
and to see today make the screening or not.
So for now it’s high they want but.

An actual number of last year of 2020 was 6.5%.

So those two numbers are very different.

So we had like, we don’t have that.

System to identify follow up and bring them back

and other, you know,

other cancer screening also

saw a dip in the 2020.

Yeah, because yeah,

that could be impacting.

States. So that report that I presented

some from that they showed like in

some states it’s quite stable and then
some states were higher or lower.

So it wasn’t like across the US that it dropped,

there were states were doing much better compared to other states.

Any final questions for Doctor Pogosian about this important work?

Well, thank you, everyone.

So, Umm for being here for this time.

And I just want to say like,

I’m new at Yale. It’s been not new.

It’s been a year and I’ll be very much interested if you have any similar research interests or areas,

I’ll be happy to collaborate.
00:41:34.955 --> 00:41:37.573 with any one of you. OK.
NOTE Confidence: 0.915284238

00:41:37.573 --> 00:41:39.330 Thank you. Thanks for coming.
NOTE Confidence: 0.915284238

00:41:39.330 --> 00:41:40.539 Thanks so much, everyone.