

Lung Cancer Screening – When is it Worthwhile?

Sometimes in medicine it seems that the more we know, the more we realize that we have a lot more to learn. If you are or have been a smoker, should you be screened for lung cancer? Are you prepared to deal with incidental findings and with the disease if they are found? These questions were addressed in a couple of articles in the medical journals I read. Two MDs wrote about the ways that [harm from screening](#) populations that are unlikely to benefit may be created. Current recommendations are that CT scanning is warranted for those from 55 to 80 years old with a history of 30 pack-years or more of smoking and have quit in the past 15 years. The authors assert that screening has been used too much in low-risk populations, leading to troublesome, incidental findings. The authors note that the lung-cancer detection rate is not all that high even in the high risk group, and that group still gets too many incidental findings. In the end, the authors call for research to better discern who will, and who will not, benefit from screening. I would also assert that patient preferences should play a role in the decision to screen or not.

Another article authored by a hand-full of experts attempted to partially accomplish what the first asked for. That group performed risk-targeted [lung cancer screening](#) by dividing about 53,000 patients into 5 groups depending on a complicated method to predict their risk of lung cancer. The patients were given low-dose CT scans or chest radiographs (control). The median follow-up time was 6 ½ years. Comparing the quality-adjusted-life-years (QALY) gained between the lowest-risk and highest risk groups, the difference was only 2.4 years. The cost of the QALY's gained ranged from \$53,000 to \$75,000. The norm for insurance payment is typically about \$100,000 per QALY. The authors conclude that any gains from screening are “attenuated and modest” in terms of QALY gains and cost effectiveness. The study is quite complex. Perhaps an expert could distil some guidance for patients on whether to be screened or not. **If I had been a smoker, I would calculate my risk of lung cancer using a [decision screening tool](#), such as the one from Memorial Sloane Kettering Cancer Center. I would not assume that the tool is unbiased.**

Medical Billing – Welcome to a Mess

[Two experts](#) looked at issues in the way medical bills are created for the delivery of care. They pointed out that the medical industry is far behind other industries with its methods, and then they note that “The unnecessarily complex, fragmented, and inefficient system of billing, coding, and claims negotiations in the US health care system employs enough people to populate small nations just to ensure that health care organizations and clinicians are reimbursed for their services.” The authors opine that this costs about a half trillion dollars per year, 80% of which is wasted. If you have been trapped between factions trying to get your money or pay arcane bills, then you understand how broken the billing system has become. Even health care professionals struggle to understand their own medical bills.



The authors propose that electronic health records could be adjusted to reduce the complexity. They also note that as consumers are asked to pay more of their healthcare costs, they are going to push back. The authors also point out that patients should know how much they will owe at the time of service. **I opine that the time is now to push hard on cost transparency. Consumers buy nothing else in total darkness. It is long past due for consumers of healthcare to demand full cost transparency.**

Medical Devices in the Real World

The Food and Drug Administration (FDA) is charged with walking a thin line between clearing devices that may be useful to patients and clearing devices that may cause harm – and this using data that are often limited. Please see last month’s book review on *Danger within Us* for further perspective on device harm. What the authors of a perspective in the *New England Journal of Medicine* propose is use of real-world data to determine the safety and effectiveness of [medical devices](#) cleared for marketing. I might note that this turns patients, in whom the device is inserted, into guinea pigs. To do this effectively, there will need to be adequate statistical methods to deal with the hodge-podge of real-world data, and there will have to be better reporting of adverse effects to the FDA. Real-world data might also be used to expand the use of a given device, but there again, the patient becomes a guinea pig. In the end, the authors seem to fall back on the need for better pre-marketing data to facilitate well-founded decisions by the FDA. They cite the example of a radio-frequency ablation of kidney nerves to control hypertension. This was approved in Europe, but a U.S. study ultimately proved that this invasive technique was no better than medications.

The message here for patients is to know the pedigree of any device that is proposed for use in your body. You may not get a second chance if it proves to be as dangerous as some cleared or approved devices. There is a natural bias to suppose that newer is better. This is often not true in the medical-device world.

Price Transparency

It is an open secret that finding prices for medical services is little more than a roll of the dice. A team of 7 experts set out to demonstrate in clear terms what we patient-consumers already know. The team looked at the [cost of 4 procedural interventions](#): upper GI endoscopy, brain MRI, cholesterol panel, and hip replacement. They searched the web using the search term “cost of (intervention) in (city).” They searched in 8 cities, identifying a total of 234 sites that provided geographically relevant, price transparency for each intervention. Overall, less than 20% of the “price transparency” sites initially inspected offered useful information.

Prices varied widely for any given location and intervention. The authors offered as an example the prices in Chicago. The ranges in price were as follows: upper GI endoscopy \$875-\$3958, brain MRI \$230-\$1950, cholesterol panel \$25-\$100, and hip replacement \$27,000 – \$80,671. Of course, it was unclear how insurance would impact the out-of-pocket costs. The authors noted that most transparency sites required a subscription. They opined that there is “substantial room for improvement.” Of course, the wise consumer would like to know the quality of the intervention. One does not negotiate a price for a car, and then discover that he was negotiating for a used Yugo rather than a new Cadillac.

Clinical Decision Making

One of the current trends in medicine is called “shared-decision making.” The idea being that a fully informed patient and her clinician engage in a thorough discussion of the options available for treatment of the patient. In the context of [medication](#) use, an MD asks whether this approach is likely to lead to optimal choices given the uncertainty inherent in most choices. According to the author, the choices clinicians make are driven by simplicity of information offered by drug company representatives, recent adverse events associated with the drug, and fear of causing harm from rare side effects. On the patient side, adherence to taking a medication may be influenced by costs. The author calls for more research as it applies to decision making in healthcare.

I would disagree with some of the author’s opinions. An empowered patient-consumer of drugs can question the clinician and do research to determine lots of information about a proposed prescription. I remember my high-school-educated mother, armed with her copy of *Worst Pills Best Pills*, managed to get doctors at Mayo Clinic and Johns Hopkins University Hospital arguing about the appropriate medication for her. She was highly mistrustful of medical care, and always did her homework.

Low-dose Aspirin for Patients with Previous PCI Undergoing non-cardiac Surgery

In this case “PCI” refers to Percutaneous Coronary Intervention, which is the placement of stents in coronary arteries. This is a very common

procedure. An editorial in the *Annals of Internal Medicine* surveyed the data on whether [low dose aspirin](#) should be continued or prescribed anew in patients that have had stents put in and are about to undergo a non-cardiac, surgical procedure.



Beware Bleeding Risk

Like many things in medicine, it's complicated. Since low-dose aspirin poses a bleeding risk, it is not recommended for previous PCI patients that are about to undergo a procedure in which bleeding risk is high. **An empowered patient that has had a PCI will ask his surgeon about use of aspirin if non-cardiac surgery is recommended.**

Right-to-Try Legislation

This kindly sounding title belies the darkness behind this bad legislation. Two experts writing in the *New England Journal of Medicine* explain that the legislation allows patients with life-threatening illness to ask a drug company to provide a drug that has completed Phase 1 trials of safety and efficacy (early in the testing process). It does several potentially harmful things. A route already exists for

desperate patients to try investigational drugs, but this happens with some oversight by the FDA. The [Right to Try](#) bill removes this oversight, leaving patients at additional risk for harm. The legislation would also block any accountability on the part of the drug maker or physician involved for harm caused to patients. It could also draw patients away from structured clinical trials that have the potential to produce quality data on risk and benefit. At the time of this writing, the House has passed a Right-to-Try bill that is similar to the one passed by the Senate. If this thing passes, as seems likely, patient advocates must increase their vigilance when investigational drugs are involved in care of patients with life-threatening disease.

Patient Pages from Medical Journals

When should a patient that fell in an assisted-living facility be transported to the ER?

<http://annals.org/aim/fullarticle/2666272/transport-emergency-department-assisted-living-residents-who-fall>

Sports-related concussions:

<https://jamanetwork.com/journals/jama/fullarticle/2671029>

Find past newsletters:

<http://patientsafetyamerica.com/e-newsletter/>



NATIONAL
QUALITY FORUM
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Answer to question: (c or d) 344%, source:

https://www.cdc.gov/mmwr/volumes/67/wr/mm6702a3.htm?s_cid=mm6702a3_w