MANY LUNG CANCER PATIENTS FEEL STIGMATIZED

People with lung cancer often feel ashamed and guilty about their illness, British researchers reported in the June 11 online edition of BMJ. The study, conducted by Alison Chapple, PhD, RN, and colleagues from the University of Oxford, United Kingdom, is based on in-depth interviews with 45 lung cancer patients between the ages of 40 and 90.

Most of the patients felt others were holding them responsible for getting sick because of the link between lung cancer and smoking. About 87% of lung cancer cases are attributable to smoking.

“People automatically think you’ve brought it on yourself,” said one study participant. “People think you’re dirty because you smoked.”

But even lung cancer patients who never smoked, or who quit decades before, felt this stigma, noted Chapple, a Senior Research Fellow in the Department of Primary Health Care.

These negative feelings caused some patients to conceal their illness, hampering their ability to get support from other people. Others in the study worried about being denied care because of the perception they’d caused their own illness.

Such findings are not surprising, said Jimmie Holland, MD, Professor and Vice Chair of Psychiatry at Memorial Sloan-Kettering Cancer Center in New York. Holland was not involved in the current study but has worked with lung cancer support groups for years.

While many cancer patients feel isolated and ashamed after their diagnosis, she said, those feelings are stronger among people with lung cancer. “It hasn’t generated the kind of sympathy it does when people have breast cancer,” Holland said. “It is a special stigma. The whole thing has been tainted by smoking.”

That taint stems in part from a lack of understanding about addiction, Holland said. Many people assume that with enough willpower, any smoker could give up tobacco. Families and friends of smokers with lung cancer may well get angry at the person for not being able to quit. But the high recidivism rate among would-be quitters speaks to the difficulty of overcoming tobacco addiction.

Even doctors are not immune to such exasperation, Holland said. “Doctors like...
to treat people who cooperate and get better,” she said.

Some patients in the study—especially those who were nonsmokers—expressed anger and dismay at the frequency with which they were asked about smoking, by both doctors and other people. Many of the smokers in the study began smoking—and got addicted—at a time when smoking was fashionable and its dangers not widely known. Being questioned about the habit increased their feelings of guilt.

Doctors do need to ask lung cancer patients about smoking, but they “shouldn’t convey an attitude of disapproval or disgust,” Holland said. “Blaming people isn’t helpful for them in coping,” she noted. “This is a problem that has to be treated with a certain level of respect and understanding.”

Doctors should make an effort to help all their smoking patients quit, Holland said, even if the patient already has lung cancer. Quitting can improve a patient’s response to treatment and, among those who survive this cancer, lower the chances of developing a second malignancy.

“I think it makes sense to be reassuring that, even if they smoked, it’s important not to smoke more,” Holland said. “Help them find the resources they need to quit.”

REPORT: WIDER MAMMOGRAM ACCESS, BETTER TECHNOLOGIES NEEDED

A recent report by the Institute of Medicine says that mammography has helped lower the death rate from breast cancer, but much could be done to improve breast cancer screening and save even more lives.

Increasing the number of women who get mammograms and making the tests more accurate should be top priorities, according to Saving Women’s Lives: Strategies for Improving the Early Detection and Diagnosis of Breast Cancer.

“Improving and increasing the use of current mammography technology is the most effective strategy we have right now for further reducing the toll of breast cancer,” said Edward Penhoet, PhD, Chair of the committee that wrote the report.

The American Cancer Society (ACS) and many other organizations recommend that women begin getting annual mammograms at age 40. But many women fail to get screened, or to be screened regularly, the Institute of Medicine report noted. In some cases, these women lack health insurance, while in others they choose not to be screened because they fear the disease or even the mammogram itself. The lack of reminder systems is a major factor in irregular screening.

But in many cases, the report said, women simply lack adequate access to screening facilities and doctors. Fewer radiologists are specializing in mammography and screening facilities across the country are closing; this combination has led to wait times of up to five months for a mammogram in some parts of the United States, the report said.

Another problem is the accuracy of mammograms. Although the best screening method for breast cancer currently available, mammograms still miss up to 17% of tumors and return a false-positive result 1 out of 10 times. Reducing that number could save up to $100 million every year, the report said.

To do that, the report recommends taking a cue from European screening programs. The United States could adopt national certification standards for radiologists, as is done in Britain. Or mammograms could all be sent to breast imaging specialists at a handful of specialized centers; this technique has helped cut down on the rate of false-positive readings in Sweden and the Netherlands.

These ideas have merit, and newer technologies like digital mammography may contribute to making them feasible, said Robert Smith, PhD, Director of Screening at the ACS.

In areas where there may be a shortage of radiologists, for instance, digital mammography