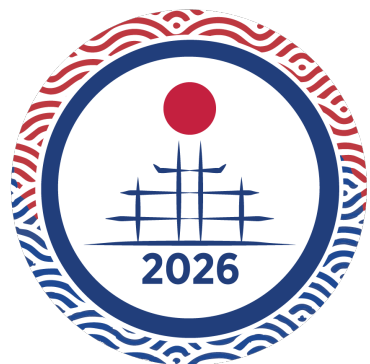




Poster #: EP04.06

Nurse-Led Community Surveillance to Address Early Detection Gaps and Emerging Lung Cancer Risk Patterns in Primary Care Settings in LMICs

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IASLC 2026 World
Conference on Lung Cancer
SEPTEMBER 12 – 15, 2026
SEOUL, REPUBLIC OF KOREA

INTRODUCTION

Lung cancer remains a leading cause of cancer mortality globally. In LMICs, presentation occurs predominantly at advanced stages (III/IV) due to delayed symptom appraisal, low perceived risk among non-smokers, and systemic referral bottlenecks.

- Traditional risk models emphasize tobacco; however, household biomass fuel smoke and prior pulmonary tuberculosis (TB) represent major emerging risk factors in rural sub-Saharan Africa.
- Frontline nurses are strategically positioned to bridge these early-detection gaps during routine primary healthcare encounters.

Objective: *To evaluate the feasibility and diagnostic yield of a nurse-led community surveillance model for identifying high-risk non-tobacco exposures, recognizing concerning symptoms, and expediting clinical diagnostic evaluation in Taita Taveta County, Kenya.*

Study Snapshot: 1,420 adults assessed across 12 primary health facilities over 12 months of surveillance (Jan–Dec 2025).

METHODS

Setting & Design:
Prospective nurse-led community surveillance across 12 primary healthcare facilities and linked outreach sites in Taita Taveta County (Jan–Dec 2025).

Population: Adults aged ≥30 years presenting for primary care or community outreach.

- Nurse-Led Assessment:**
- Red-flag symptoms** (cough ≥3 weeks, chest pain, hemoptysis, unexplained weight loss).
 - Exposure history** (biomass fuel smoke, occupational dust/inhalants, tobacco pack-years).
 - Past medical history** (prior pulmonary TB, chronic lung disease).

Referral Pathway: High-risk patients navigated via standardized triggers to Moi County Referral Hospital Cancer Centre for chest imaging and specialist evaluation.

DISCUSSION AND CONCLUSION

- Actionable Take Away Message**
- **Look beyond smoking:** nurse-led surveillance is feasible and potentially scalable for bridging early lung cancer detection gaps in rural LMIC settings. Broadening risk screening beyond tobacco to biomass smoke and past TB captures at-risk populations routinely missed by conventional guidelines with a median referral-to-evaluation interval of 3.5 weeks compared with a pre-intervention baseline of 16 weeks.
- Future Direction for Research**
- Scale nurse-led, non-tobacco-inclusive screening to additional primary care sites across Taita Taveta County and comparable LMIC settings, and evaluate its longer-term impact on stage-at-diagnosis, time-to-treatment, and survival outcomes.

REFERENCES & ACKNOWLEDGEMENTS

References

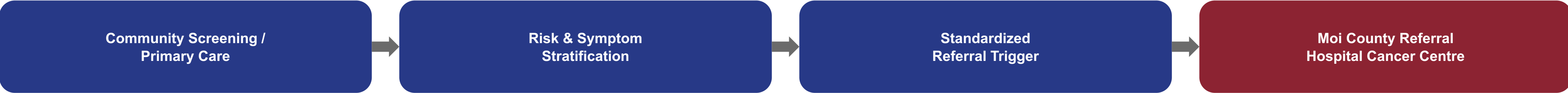
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ACKNOWLEDGEMENTS
The author acknowledges the healthcare workers, community health teams and primary care providers supporting cancer awareness, risk assessment, referral and early detection activities across Taita Taveta County.

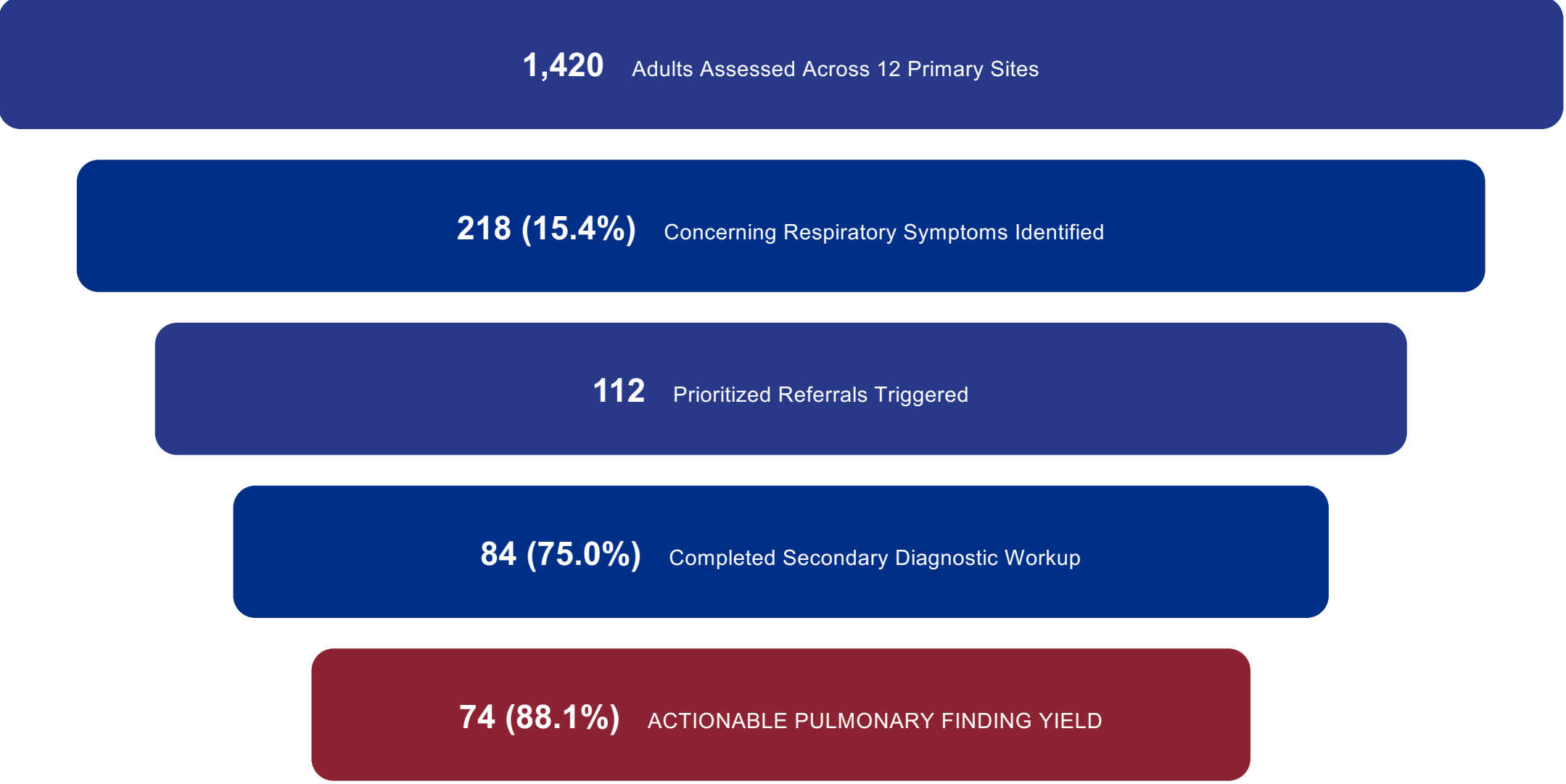
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AI Disclosure: ChatGPT was used for language editing and structural refinement of the submitted abstract. Claude (Anthropic) was used to assist with poster content structuring and layout based on the author’s original data and analysis. All scientific content, data, and interpretation are original and reviewed by the author(s).

RESULTS

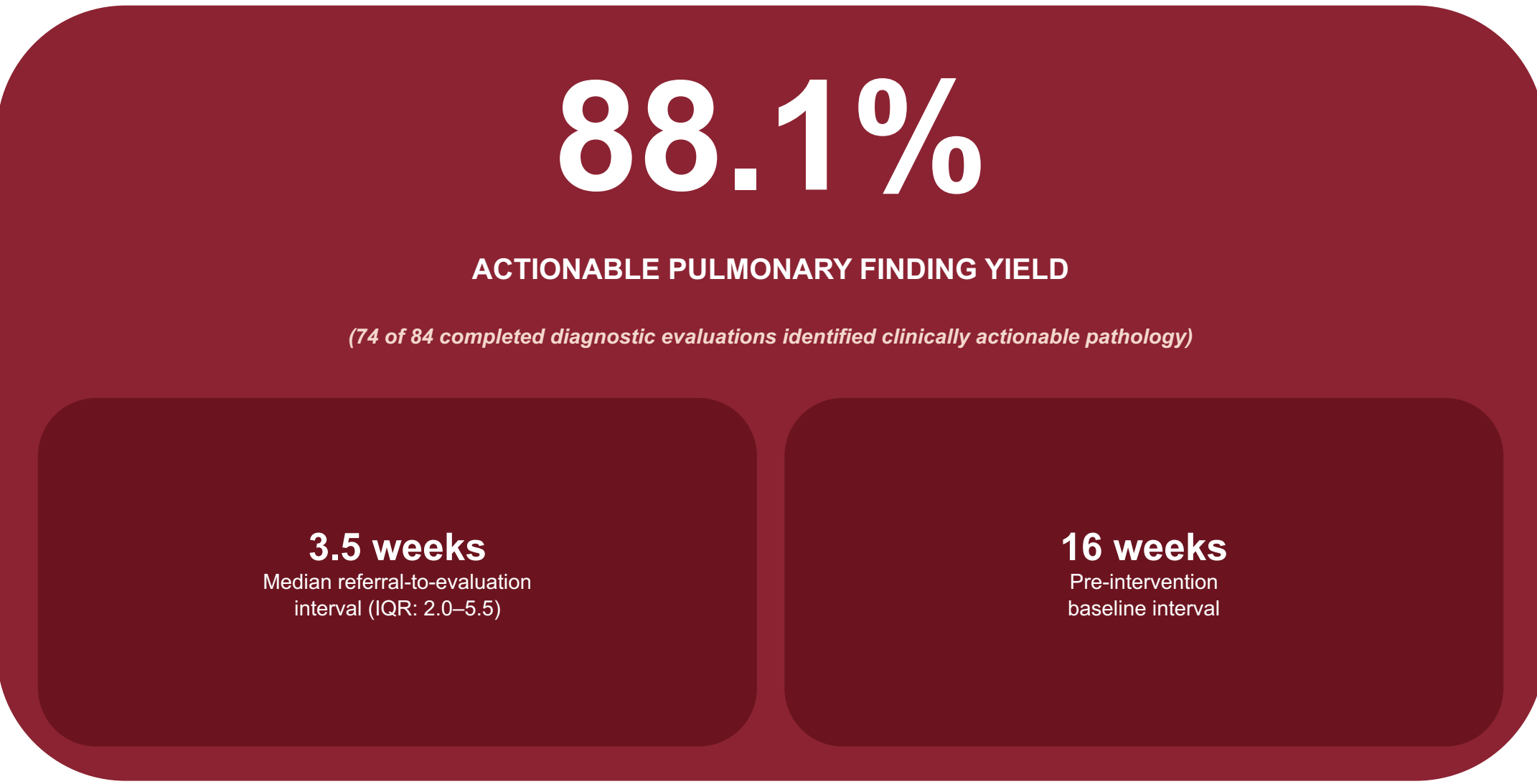
NURSE-LED EARLY-DETECTION PATHWAY



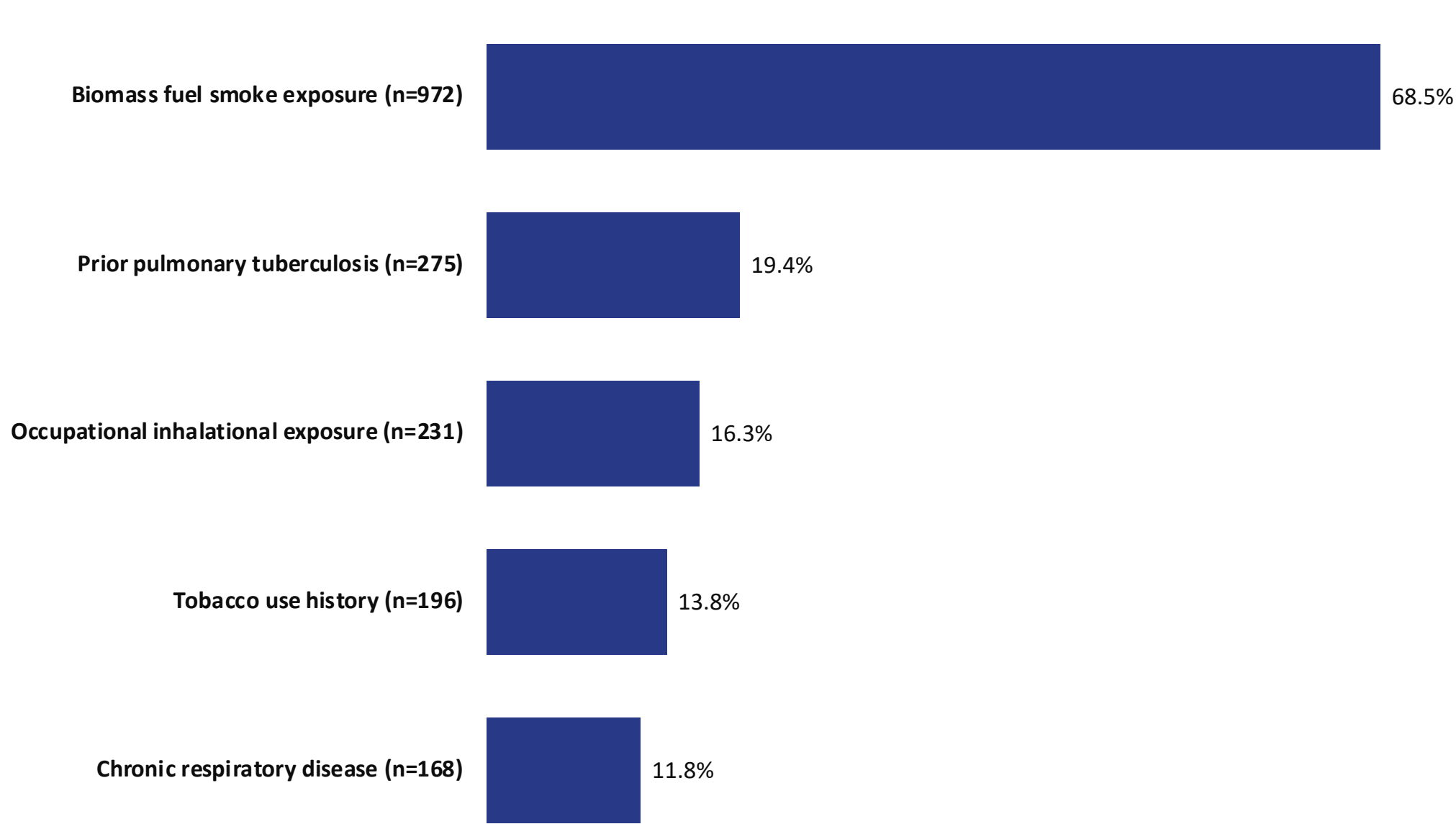
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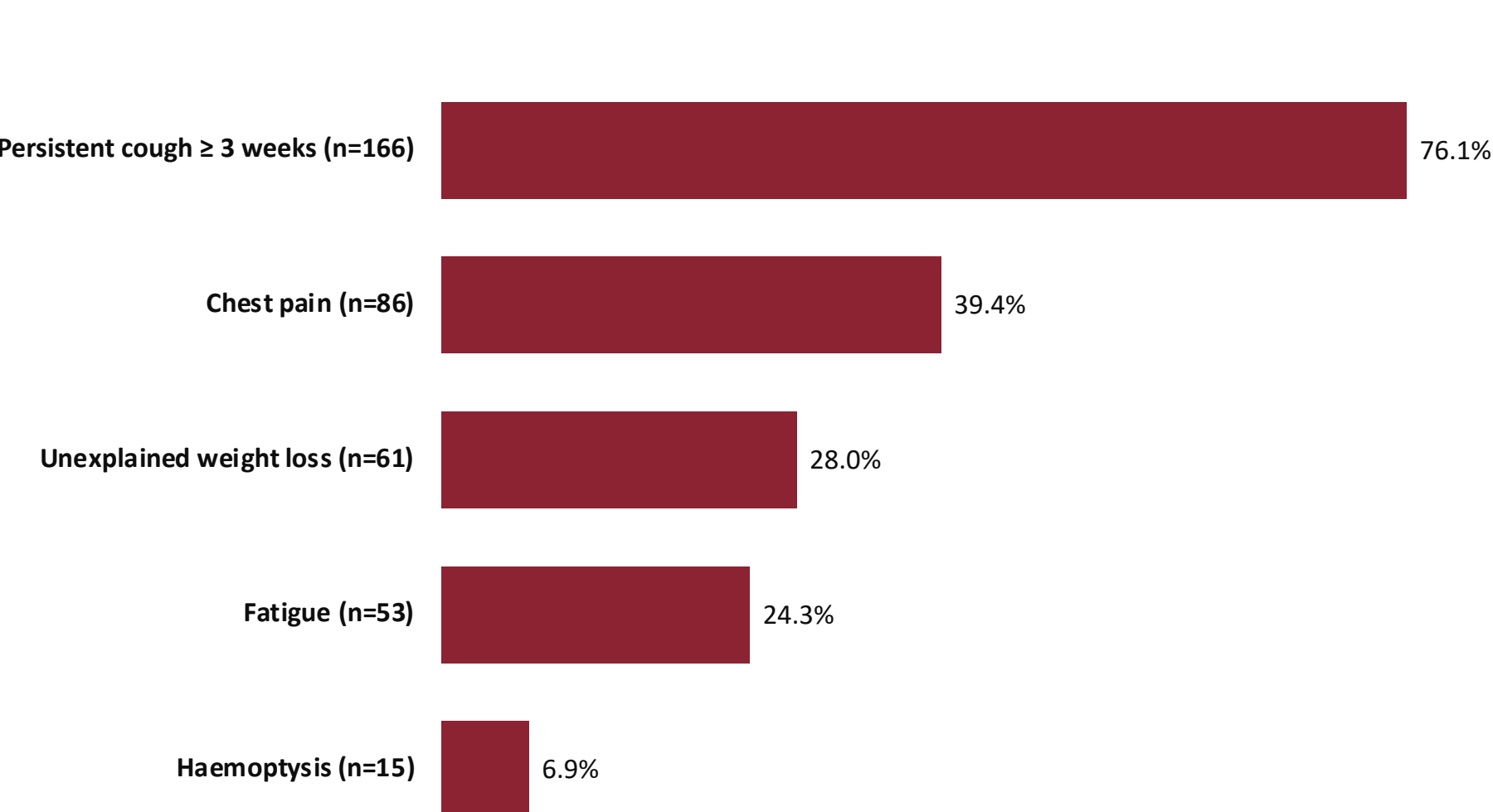
KEY OUTCOME



RISK FACTOR PREVALENCE



SYMPTOMS IDENTIFIED (N=218)



DIAGNOSTIC OUTCOMES (N=84 COMPLETED WORKUPS)

Diagnostic Category	n	%
Confirmed NSCLC	4	4.8%
Highly suspicious malignancy (inconclusive biopsy)	2	2.4%
Suspicious pulmonary nodules / lesions requiring follow-up	12	14.3%
Active or recurrent pulmonary tuberculosis	18	21.4%
Post-TB fibrocavitary disease / bronchiectasis	22	26.2%
COPD / Chronic asthma	16	19.0%
Normal / Non-specific benign findings	10	11.9%
Total Actionable Findings	74	88.1%