JNCI: Journal of the National Cancer Institute, 2023, **115(2)**, 226–227

https://doi.org/10.1093/jnci/djac235

Advance Access Publication Date: 19 December 2022

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RE: Sociodemographic survival disparities for lung cancer in the United States, 2000-2016

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We read with great interest the article by Brower et al. (1), "Sociodemographic Survival Disparities for Lung Cancer in the United States, 2000-2016." Although we commend the authors' efforts in reporting on this important topic, we express concerns that the presentation confirms the invisibility of the LGBTQI+ population. Since 2011 the Institute of Medicine has recommended to include LGBTQI+ individuals in studies. The study considers the period 2000-2016; however, our considerations come from the observation that to date, these data are still omitted in the databases and/or the difficulties to collect them in a complete and correct way in respect of the privacy and sensitivity of individuals have not yet been overcome. Understanding and investigating the reasons for the disparities is fundamental to designing new effective prevention and treatment strategies. There is growing attention in health research in describing the mechanisms and pathways by which marginalization and inequalities of any kind (race, ethnicity, sex, gender, etc.) could affect health (2, 3). It is time to understand that the approach necessary to eliminate discrimination must and can only be comprehensive and unique, but it is, above all, the time to act. We must broaden our gaze and commit ourselves to offer all disadvantaged and marginalized populations our same opportunities, especially in health care. We must intercept and remove all conditions that cause inequity and injustice. The racial and ethnic characteristics that increase the risk of developing lung cancer and hinder adherence to screening programs are unfortunately not the only ones. Sex and gender are important variables in this context (4), which often intersect with race and ethnicity. Health-care barriers and discomfort with screening procedures may influence cancer diagnosis, progression, and outcomes also in sex and gender minority individuals (SGM).

SGM individuals are at increased risk for some cancers with cancer risk behaviors, such as smoking and several other unhealthy behaviors more common in these populations. A total 7.1% of US adults self-identified as LGBTQI+, and the percentage increases to approximately 21% of Generation Z Americans who have reached adulthood (5).

Data and results from clinical trials and tumor registries that do not include the LGBTQI+ population perpetuate disparities and do not reflect the actual situation of the general population. It is imperative to include these groups in studies to understand their potential cancer risk and the variations in treatment outcomes (6, 7). Most of the data currently available do not allow to identify individuals belonging to SGM minorities, confirming the urgency for much more research and robust data collection on gender identity. The administrative, legal, and personal data should not be underestimated in addition to the cultural, social, psychological, and educational barriers that hinder an inclusive care offer. Data collection for entry into electronic health records represents a critical point of this change, and emerging opportunities for culturally responsive data collection hold promise for further advancing LGBTQI+ health equity. Gender identity information and anatomical inventories can facilitate developmentally appropriate delivery of care; therefore, health-care organizations should adopt well-defined strategies for data collection.

Funding

No funding was received for this work.

Notes

Role of the funder: Not applicable.

Author disclosures: Authors declare that they have no conflicts of interest.

Author contributions: Conceptualization, writing-original draft, writing—review & editing: MMS, LG and MDM.

Received: December 8, 2022. **Accepted:** December 13, 2022

Data availability

No data were analyzed or generated in this correspondence.

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