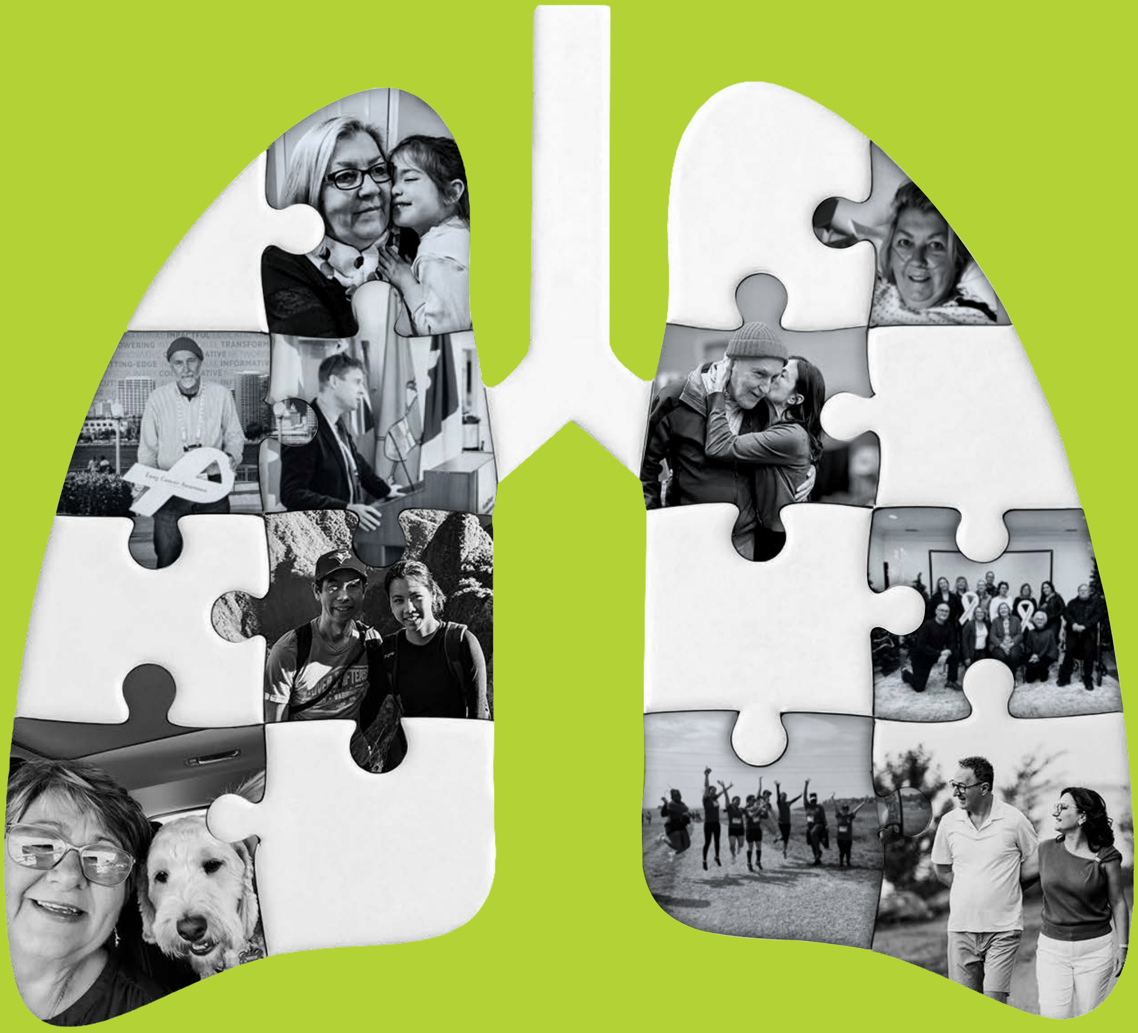

STORIES THAT UNITE US. CHANGE THAT MOVES US.

2025 Faces of Lung Cancer Report

LUNG
CANCER
CANADA

NO ONE HAS TO FACE LUNG CANCER ALONE.

Your Comprehensive Guide to Lung Cancer is designed to help patients, their loved ones, caregivers, and health professionals navigate this journey.

+ Access the guide

LUNG CANCER CANADA CANCER PULMONAIRE CANADA


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Your Comprehen
to Lung Cancer

Developed by Lung Cancer Canada fo
lung cancer, caregivers and healthcar

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FRAMING THE FUTURE: WHERE WE ARE, WHERE WE'RE GOING

A Message from Dr. Rosalyn Juergens and Shem Singh

At Lung Cancer Canada, our work has always been grounded in one truth: lung cancer is not just a medical issue—it's a human one. Behind every statistic is a person, a family, a story. These stories don't just inform us—they unite us, move us, and compel us to act.

The 2025 Faces of Lung Cancer Report builds on the momentum of 2024—a year defined by urgency, collaboration, and meaningful progress. Through summits, support groups, policy engagement, social work services, and more – along with a dynamic new website and the invaluable resource Your Comprehensive Guide to Lung Cancer – we continued to amplify the voices of people living with lung cancer and the clinicians who care for them. We pushed for faster access to innovation, championed patient-centred policy reform, and supported communities with the tools they need to navigate care.

This year's report reflects a shift from awareness and access to impact and transformation. From national advocacy to the bedside, lung cancer care in Canada is changing—but not fast enough. Too many patients are still waiting. Too many treatments are delayed. And too many lives are being lost unnecessarily.

That's why this year, more than ever, we're focused on accelerating progress. We are speaking louder, acting faster, and building stronger coalitions. Through research, partnerships, and patient-driven advocacy, we are pushing the system to do better—because people with lung cancer deserve better.

The stories in this report are powerful. They are hard and hopeful. They reflect where we are—and they help us imagine where we need to go. Together, we can create a future where lung cancer care is timely, equitable, and driven by those who know it best.

We're grateful for your continued support and shared commitment to change.

R. Juergens

Dr. Rosalyn Juergens
President
Lung Cancer Canada

Shem Singh
Executive Director
Lung Cancer Canada

ABOUT LUNG CANCER CANADA

ABOUT LUNG CANCER CANADA

Who We Are & How We Help

At Lung Cancer Canada, we do one thing—and we do it with focus, urgency, and impact: lung cancer. As Canada's only national charity dedicated exclusively to this disease, we are not about lung health in general—we're about saving lives, pushing science forward, and ensuring that no one faces lung cancer alone.

Lung cancer is the most commonly diagnosed cancer in Canada and the leading cause of cancer death. It affects not only the physical health of patients, but also places an emotional and financial burden on families and care partners.

In the face of this challenge, Lung Cancer Canada is here—providing support, trusted education, and strong advocacy. We ensure that patient voices shape healthcare decisions and treatment access. We fund research to drive innovation, improve outcomes, and advance care. We fight stigma and advocate for change—from earlier detection to better treatment options—so we can ultimately conquer this disease.

Through these efforts, we empower the lung cancer community and drive the progress Canadians with lung cancer deserve.

Learn more at: **www.lungcancercanada.ca**

OUR MISSION

- To increase public awareness of lung cancer.
- To support and advocate for people living with lung cancer and their families.
- To provide reliable, accessible educational resources for patients, caregivers, healthcare professionals, and the public.

WHAT WE DO

Support Programs

We offer a range of services that provide practical guidance, emotional support, and reliable information to people living with lung cancer and those who care for them.

Education & Awareness

Through national campaigns and community outreach, we raise awareness about lung cancer risks, symptoms, and the importance of early detection—empowering Canadians to take charge of their health.

Advocacy

We advocate for equitable access to lung cancer screening, testing, and treatment, working to influence policy and eliminate the disparities that patients face across the country.

Research Investment

We support research that advances understanding, improves care, and accelerates innovation—bringing new treatments and hope to the lung cancer community.

BOARD OF DIRECTORS

At Lung Cancer Canada, we are driven by purpose—and powered by the people who lead us. Our Board of Directors brings together an exceptional group of individuals whose vision, expertise, and commitment fuel everything we do. With their leadership, we continue to focus on what matters most: **saving lives, advancing science, and ensuring no one faces lung cancer alone.**

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MEDICAL ADVISORY COMMITTEE

Lung Cancer Canada's Medical Advisory Committee is at the heart of our mission. This dedicated group of clinicians and researchers brings world-class expertise, deep compassion, and an unwavering commitment to improving outcomes for people affected by lung cancer. Their guidance shapes our advocacy, strengthens our educational programs, and ensures we remain grounded in science, evidence, and patient-centred care.

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STATE OF LUNG CANCER IN CANADA

STATE OF LUNG CANCER IN CANADA

Today, lung cancer remains the most commonly diagnosed cancer in Canada, and the most common cause of cancer deaths. This year, more than 20,000 Canadians will die from lung cancer—more than breast, prostate, and colorectal cancers combined.

While advances in research and treatments in the last decade have translated into the survival rate being the highest it has ever been, nearly 70% of lung cancer diagnoses are still made at a late stage, when the disease has already spread through the body and survivorship is low.

24%

LUNG CANCER IS RESPONSIBLE FOR 1 IN 4 CANCER DEATHS AMONG CANADIANS

MORE THAN

20,000

CANADIANS WILL DIE FROM LUNG CANCER EACH YEAR

70%

ARE DIAGNOSED AT STAGE 3 & 4

EACH YEAR, MORE THAN

32,000

CANADIANS WILL BE DIAGNOSED

1 IN 14 CANADIANS EXPECTED TO BE DIAGNOSED WITH LUNG CANCER IN THEIR LIFETIME

STORIES THAT UNITE US. CHANGE THAT MOVES US.

FROM DIAGNOSIS TO DISCOVERY

A Conversation with Judy Hollingsworth

The Power of Screening and Early Detection

When Judy Hollingsworth walked into her doctor's office more than 14 years ago, she had no idea her life was about to change. It wasn't a diagnosis that altered her course—it was a simple poster on the wall, advertising a research study on early detection for lung cancer.

"I almost didn't call," she says. "I was scared to know. But I knew I had to."

Judy had good reason to be concerned. Both her parents died of lung cancer—her father after surgery came too late, her mother after a chance ER visit revealed cancer that had already spread. Combined with her smoking history and childhood bouts of pneumonia, Judy knew the risk was real.

"I don't think I ever had great lungs," she says. "But back then, screening wasn't something anyone really talked about."

That poster led Judy to join a research study in 2011 led by Dr. Stephen Lam at BC Cancer, a national leader in lung cancer screening. She began routine scans and testing every few months, consisting of bloodwork, pulmonary function tests, and bronchoscopies to track her lungs over time. Years passed—until 2014, when doctors noticed a few small nodules. As one began to grow, surgery was scheduled.

Even then, the road wasn't easy. Surgery delays due to a shortage of thoracic surgeons caused months of uncertainty. And quitting smoking during the stress of it all was its own challenge. But when the operation finally came, the cancer was still in Stage I. No chemo, no radiation—and most importantly, a second chance.

"If it hadn't been for that poster, I would have walked around with cancer and never known," Judy says. "I had no symptoms. None. That's what's so scary. Lung cancer really is a silent killer."

Screening Saved Her Life—But It Shouldn't Be About Luck

Judy's story is powerful—and rare. Most lung cancer diagnoses in Canada still happen too late, when treatment options are limited and outcomes are poor.

"People don't even know screening exists," she says. "And if they do, they don't know how to access it. Why did I only find out because of a poster? Where's the awareness?"

Today, Judy remains in the program and continues to receive regular CT scans. "There are some spots again, so I'm back to every six months," she says. "But I'm being watched. That's what matters."

More Than Scans: The Search for Support

Despite the quality of her care, Judy describes the emotional experience as isolating. She didn't receive resources or information on where to turn for support—and felt the stigma of a lung cancer diagnosis.

"No one gave me a pamphlet. No one mentioned a support group," she recalls. "I went to a breast cancer group because that was all I could find."

She later discovered Lung Cancer Canada's virtual support groups, a lifeline she believes more people should know about. Stigma was another burden: "Yes, I smoked. So did my parents. But it's not just about that. People get lung cancer for many reasons—and no one deserves to be judged for being sick."

A Message to Decision-Makers: Awareness Is Action

Judy is clear about what she wants healthcare leaders to understand: "Make people aware. Fund screening. Put signs up. I've been to cancer centres for years and never seen one thing about lung cancer screening."

To her, the solution is simple: equitable, timely access to early detection. "I was lucky," she says. "But this shouldn't be about luck. Everyone deserves the chance I had. I'm so thankful to Dr. Lam for allowing me to participate in his research study, but I don't know where I'd be right now if it hadn't been for him."

Judy's experience captures what this report is all about: transforming individual stories into collective action. Early detection changed her life, and could do the same for thousands of others if systems are strengthened and awareness becomes the norm.

"Something so horrible doesn't sound so bad when you've had the kind of care I've had," Judy reflects. "But no one should have to rely on chance. We can do better, and it starts with making people feel seen, supported, and screened."

> **"I had no symptoms. None. That's what's so scary. Lung cancer really is a silent killer."**

FROM DIAGNOSIS TO DISCOVERY

A Conversation with Dr. Brandon Sheffield

Unlocking Precision Care

In the complex world of lung cancer care, the focus often falls on the faces patients see—oncologists, surgeons, radiologists. But behind the scenes, long before treatment begins, another critical figure is quietly shaping a patient's future: the pathologist.

"People don't always realize it," says Dr. Brandon Sheffield, a molecular pathologist at William Osler Health System in Brampton, Ontario. "But everything in a lung cancer diagnosis—from treatment options to survival—starts with what happens under the microscope."

Pathology: The Hidden Catalyst in Cancer Care

Pathologists are the first to confirm whether a suspicious mass is malignant, what type of cancer it is, and which mutations or biomarkers may be driving it. These molecular fingerprints are what make precision medicine possible – giving patients access to targeted therapies that are more effective and less toxic than traditional chemotherapy.

"Every lung cancer is biologically unique," explains Dr. Sheffield. "The more we understand the genetics behind a tumour, the better we can match patients with treatments that give them the best chance – not just to live longer, but to live better."

But unlocking those answers depends on having the right sample, handled the right way, in the right hands. If the tissue is too small, degraded, or delayed, critical tests may be impossible, and the patient may lose valuable time.

"Lung cancer moves fast," says Dr. Sheffield. "Delays don't just cause stress, they can cost lives. Every day matters."

Systemic Gaps, Uneven Access, and the Cost of Waiting

Across Canada, access to high-quality, timely biomarker testing remains uneven, with deep consequences for patients depending on where they live.

Dr. Sheffield recently co-authored a national study that revealed striking disparities in turnaround times for molecular testing. Just 15% of labs delivered results within the recommended 2-week window. Nearly one-third took more than a month. "That kind of variability can change everything for a patient," he says.

In some regions, hospitals lack the infrastructure or staffing to run advanced tests in-house, sending samples to research or out-of-province labs where patient diagnostics compete with academic workloads. "We've had samples delayed because of long queues or the wrong person reviewing them. That's not a failure of science – it's a failure of systems."

At Brampton Civic Hospital, Dr. Sheffield helped cut average biomarker turnaround from 64 days to just three. The difference? Not new tech, but local leadership, clinical oversight, and a culture of urgency.

"We didn't build a new lab. We made lung cancer a priority," he says. "When the system sees the patient behind the sample, things move faster."

Innovation with Purpose: What's Next in Diagnostic Tools

While system improvements are critical, new technologies are also transforming what's possible in lung cancer diagnostics:

- Digital pathology converts tissue slides into high-resolution images that can be scanned, shared, and analyzed using AI – speeding up diagnoses and improving accuracy.
- Liquid biopsies offer a non-invasive alternative by analyzing Tumour DNA in a blood sample, reducing the need for repeat tissue biopsies.
- Tissue-sparing assays make it possible to test for more biomarkers using smaller samples, an essential advance when tissue is limited.

"These tools are game-changers," says Dr. Sheffield. "But they only work if the people, policies, and workflows around them are ready to support them. Technology isn't a silver bullet. It needs a strong clinical backbone."

A Call to Action: From the Lab to the Front Lines

For Dr. Sheffield, the message to his colleagues - and the broader system - is clear.

"Pathologists aren't just lab techs. We're physicians. We're responsible not just for detecting cancer, but for ensuring patients are fully profiled and positioned for the right treatment," he says. "We need to own that role, and fight delays with the same urgency our clinical colleagues do."

That sense of collective responsibility, he says, is how lung cancer care will continue to evolve – through better coordination, shared standards, and a unified commitment to equitable access.

"I've seen what happens when people rally behind a shared goal. We're not just processing samples, we're changing lives."

> **"Excellence shouldn't be the exception. It should be the standard everywhere."**

The Role of Advocacy: Turning Insight into Impact

Dr. Sheffield credits much of the momentum in biomarker testing to groups like Lung Cancer Canada, which have pushed governments and health systems to recognize the power of diagnostics in driving survival.

"Every time advocates raise their voices, it echoes inside the lab," he says. "It leads to more resources, clearer guidelines, and faster care. But there's still a long way to go."

And what would progress look like to him?

"No patient should be denied personalized care because of where they live or how long a lab takes," he says. "Excellence shouldn't be the exception. It should be the standard everywhere."

ACCESS AND INNOVATION IN TREATMENT

A Conversation with Dr. Paul Wheatley-Price

From Breakthrough to Bottleneck: The Promise—and Problem—of Lung Cancer Treatment in Canada

Dr. Paul Wheatley-Price, medical oncologist and former President of Lung Cancer Canada, has spent decades standing at the intersection of patient care and health policy. He has seen firsthand what cutting-edge science can achieve—and how frustratingly slow Canada's systems can be to deliver it. In his view, the lung cancer treatment landscape is a study in contrasts: remarkable progress colliding with avoidable, and sometimes fatal, barriers.

"We have a lot to be proud of," he begins. "We're seeing survival rates improve faster than for any other cancer, thanks to advances like targeted therapies, immunotherapy, and broader access to screening. But progress only matters if it reaches people. And right now, too many are being left behind."

Precision Medicine: Game-Changer with Limits

Dr. Wheatley-Price credits much of the survival gain to precision medicine—an approach that matches treatment to the specific genetic drivers of a person's cancer. For patients, it can mean years of life instead of months. "We're no longer talking about one type of lung cancer. There are dozens of subtypes. And for many, we have therapies that are not just effective—they're transformative," he explains.

But those therapies are only useful if patients can access them. "Even when we identify the right mutation and the right treatment exists, that doesn't mean we can deliver it. Canada's testing infrastructure, drug approval systems, and provincial formularies often don't move at the same speed as the science. And in lung cancer, time is everything."

A System That Delays—and Denies

Canada’s pathway from lab discovery to patient bedside is complicated—and often painfully slow. “First, Health Canada approves the drug. Then it goes to the Canadian Drug Agency or Quebec’s INESSS for health technology assessment. After that, it enters pricing negotiations, and only then can provinces decide whether to fund it,” he explains. “Every step is a potential dead end—or a delay that patients simply can’t afford.”

Some drugs, such as the dabrafenib/trametinib combination, never make it through the full process. Others, like tepotinib or amivantamab, take years only to differ in availability depending on the province. “There are patients who live five minutes across the river in Quebec, who can’t receive the same drug I can offer someone in Ottawa, and vice versa,” he says. “It’s frustrating and unfathomable as a physician, and utterly consequential as a patient. We pride ourselves on universal healthcare, but when it comes to cancer drugs, your postal code matters.”

When Innovation Fails to Reach Patients

The emotional toll isn’t limited to those living with lung cancer—it weighs on clinicians, too. “It’s heartbreaking,” Dr. Wheatley-Price says. “I can look a patient in the eye and know exactly what treatment they need. I know it exists. But when I can’t offer it because it’s stuck in the bureaucratic process, that causes a kind of moral injury.”

> **“We have the tools. We have the science. What we need is the system to catch up—because lives are hanging in the balance.”**

He draws a sharp line between medical possibility and systemic reality. “The science is doing its job. But if we don’t fix the system around it, we’re wasting its potential—and we’re costing lives.”

Real Progress—and What Needs to Happen Next

Despite his frustrations, Dr. Wheatley-Price sees reasons for optimism. Lung cancer screening programs are expanding, molecular testing is improving, and advocacy efforts are gaining ground.

“We’ve made incredible headway—not just in treatment, but in awareness, policy conversations, and survivor engagement,” he says. “People with lung cancer are now living long enough to become advocates. That’s a huge cultural shift.”

But he warns against being dazzled only by the next big breakthrough. “Yes, new therapies like antibody-drug conjugates are exciting. But let’s not ignore the basics. We still don’t have equitable access to the therapies we already know work. Let’s make sure we’re delivering standard of care before we chase the next frontier.”

Advocacy, Equity, and Urgency

For Dr. Wheatley-Price, advocacy is central to changing the system—and that includes challenging the stigma that still clings to lung cancer. “It’s a disease still tied to smoking in the public imagination, and that stigma has long limited public support, funding, and compassion,” he says.

And while the growing number of non-smoking advocates is helping shift perceptions, he cautions against creating new divides. “Everyone with lung cancer deserves excellent care, regardless of their tobacco exposure. This isn’t about ‘deserving’ patients. It’s about everyone with lung cancer.”

He also points to organizations like Lung Cancer Canada as powerful agents of change. “We’ve seen progress because patients and clinicians are standing together, raising their voices, and demanding more. It’s working—but we can’t stop now, and we are in this for the long haul.”

His message to decision-makers is clear: “We’re not asking for miracles and we understand the pressures on a public healthcare system. We’re asking for fairness, consistency, and urgency. We have the tools. We have the science. What we need is the system to catch up—because lives are hanging in the balance.”

ACCESS AND INNOVATION IN TREATMENT

A Conversation with Dr. Lorraine Bell

From Pediatrician to Patient: A Journey Through Lung Cancer Care

As a pediatric nephrologist at Montreal's McGill University Health Centre, Dr. Lorraine Bell spent decades treating children with serious kidney diseases. She never imagined she'd find herself navigating a life-threatening diagnosis of her own. But in May 2020, amid the first wave of the COVID-19 pandemic, Lorraine's life changed overnight.

"I had no symptoms pointing to lung cancer. What brought me to the hospital were severe back pain and neurological symptoms—weakness, loss of leg coordination, difficulty walking. Imaging revealed a collapsed vertebra invaded by tumour, and eventually, the cause: metastatic lung cancer," she recalls. "Even as a physician, I wasn't prepared for what followed."

The diagnosis was grim—stage IV non-small cell lung cancer with metastases to her spine. Searching for answers, Lorraine turned to the medical databases she had long relied on for her own practice. "The data I could access put my one-year survival odds as low as 10%. I thought, 'This might be it.'"

Precision Medicine, Hope—and Hurdles

What gave Lorraine a fighting chance was molecular testing. A second biopsy revealed a rare mutation—MET exon 14 skipping—making her eligible for targeted therapies that could dramatically change her prognosis.

"I was fortunate. I had access to biomarker testing, and a care team who pursued it despite early biopsy challenges," she says. She was started on crizotinib, a targeted therapy, and remained stable for three years. When brain metastases developed in 2023, her oncologist recommended tepotinib, a newer, more effective drug for treating brain lesions. But accessing that drug was another battle entirely.

Barriers to Access: "It Wasn't Just the Cancer I Was Fighting"

Because of existing coverage rules in Quebec, Lorraine's oncologist's request for tepotinib was denied—twice. The Régie de l'assurance maladie du Québec (RAMQ) ruled she had "failed" her first-line therapy, even though crizotinib's inability to cross the blood-brain barrier had nothing to do with failure—it simply wasn't designed to address brain metastases.

Facing a critical health crisis, Lorraine paid out of pocket—$10,000 per month—to begin treatment with tepotinib. "It was terrifying. I had to dip into my retirement savings just to stay alive," she says. "It felt absurd. The right drug existed. I had the mutation. I had the medical evidence. I had responded very well to tepotinib after paying for it myself. It was available in Quebec but only for a select group of lung cancer patients, and the system made me wait."

She filed a legal appeal with the provincial tribunal—and eventually RAMQ agreed to fund the drug for her. But by then, she had suffered serious complications: headaches, brain swelling, loss of balance, and needed emergency brain surgeries to remove 2 expanding tumours.

"I'm one of the lucky ones," she says. "I had medical knowledge. I had support. I knew how to fight back. But imagine someone facing this alone."

Inside the System, But Still On the Outside

Despite her medical training, Lorraine says the experience left her feeling vulnerable and isolated.

"After spinal surgery, I couldn't walk and was transferred between hospitals without clear communication. I didn't meet my oncologist for days. COVID made it worse—no visitors, no support. It was hot, uncomfortable, and frightening."

She emphasizes how critical self-advocacy was during her care. "There were moments where I had to push—to ask for transfers, to get timely imaging studies booked. If I hadn't spoken up, I don't know when these would have happened.

> **"Lung cancer doesn't care where you live or what you've done. Everyone deserves a chance—not just to survive, but to live. We have the science. Let's match it with the systems to deliver."**

Her advice to other patients? "Always have someone with you. Speak up. Ask questions. Take notes. The system is overburdened, and unless you speak up, things could fall through the cracks."

The Promise of Research. The Reality of Access.

Today, Lorraine continues on tepotinib, which has kept her cancer stable. "I originally had eight brain metastases—six disappeared after four weeks on the drug. The remaining two were treated with precision radiation. That's the power of targeted therapies."

But while precision medicine gives hope, she's concerned the focus on breakthrough science sometimes eclipses the urgent need for system-wide change.

"We get excited about the next big thing, and that's important. But we still don't have consistent access to the therapies that already work," she says. "The challenge isn't just discovery—it's delivery."

Living with Lung Cancer, and Living Fully

Now, five years post-diagnosis, Lorraine reflects with a mixture of gratitude and realism. "I'm still here. I didn't think I would be. I'm not the same person I was before—I've had to leave work, manage side effects, and adapt to a new normal—but I've also gained a new perspective life and am deeply grateful for everyday moments of joy."

While she credits her medical knowledge and social supports, she knows that shouldn't be the determining factor in who lives or dies.

"I'm alive because someone discovered a mutation. Because someone created a drug. Because I fought hard to access it. But it shouldn't be this difficult for anyone."

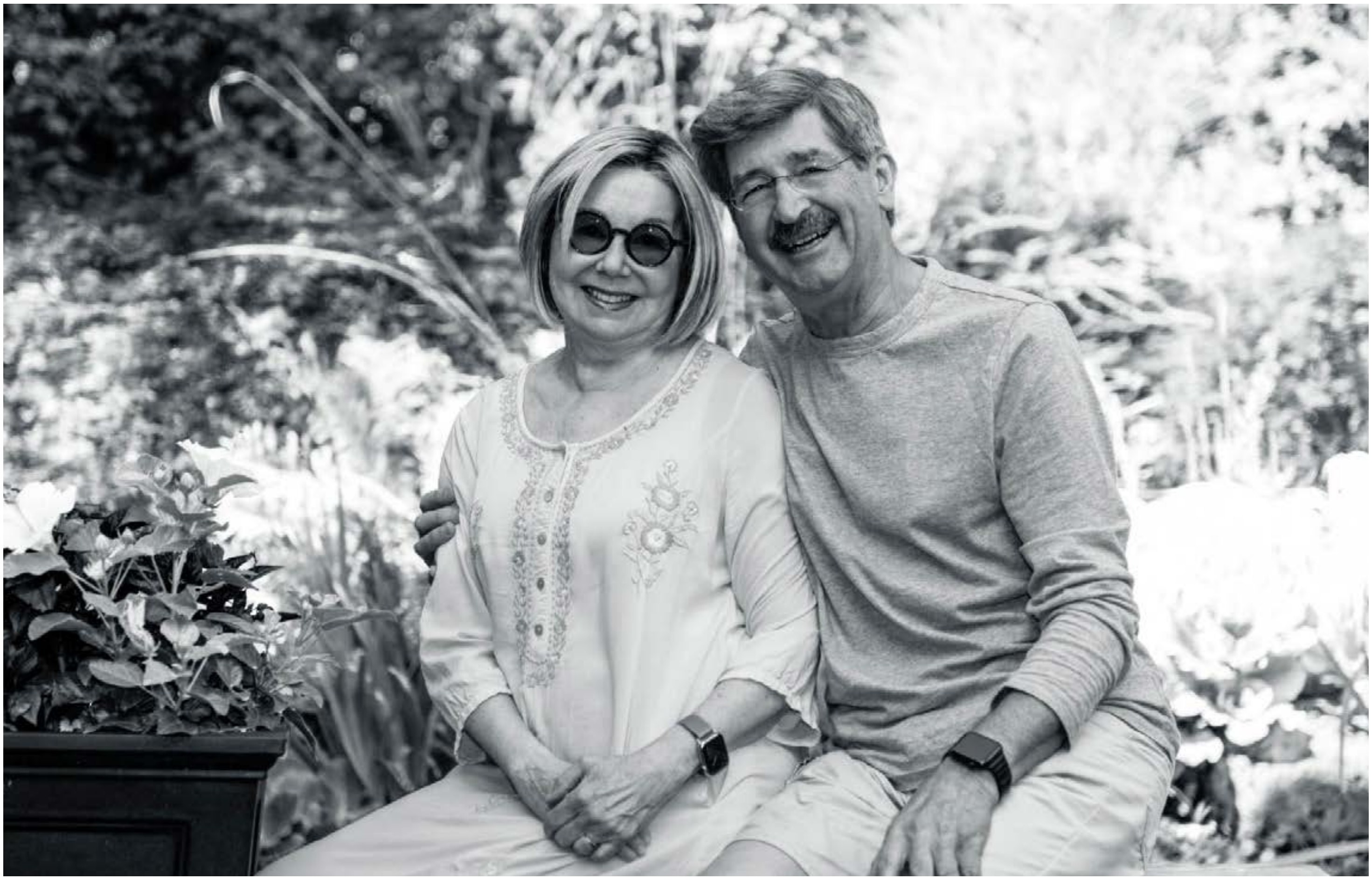
She has also spent time preparing for what comes next, reading about palliative care and planning for the future. "We should all talk about these things more—legacy, dignity, and how we choose to live with the time we have."

A Call to Action

Lorraine's story is one of resilience, courage, and determination—but also one of system failure. The promise of innovation can only be realized when access is timely, equitable, and grounded in patient need, not bureaucratic delay.

Her message to policymakers and healthcare leaders is clear:

"Lung cancer doesn't care where you live or what you've done. Everyone deserves a chance—not just to survive, but to live. We have the science. Let's match it with the systems to deliver.



LIVING WITH LUNG CANCER

A Conversation with Angus Pratt

Rebuilding a Life, One Day at a Time

For Angus Pratt, living with lung cancer isn't just about surviving — it's about adapting, advocating, and redefining what it means to live fully in the face of uncertainty. Diagnosed in 2018, Angus has spent more than seven years navigating treatment, recurrence, and the quiet daily battles that don't always show up on a scan.

Once an early riser with a structured daily routine, Angus now measures his energy more deliberately. "I still do the same things, just later and slower," he says with a smile. "It's about conserving spoons," he adds, referencing the well-known "spoon theory" of energy management used by people with chronic illness.

For Angus, the shift has been both physical and emotional. Fatigue lingers, compounded by lower red blood cell counts and reduced lung capacity. "Exercise used to be effortless. Now it takes planning — and recovery time."

A Diagnosis That Changed Everything

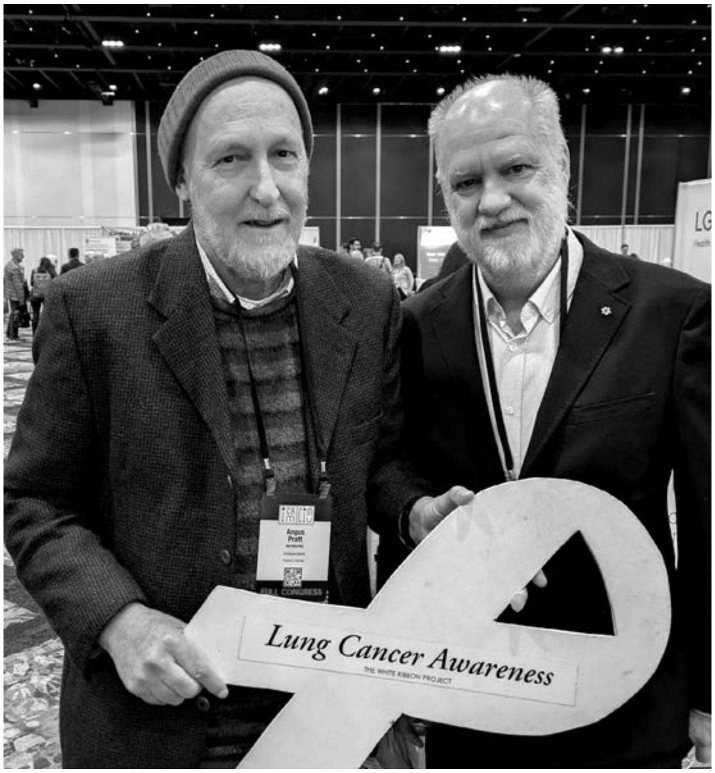
Angus's lung cancer diagnosis came as a shock — discovered incidentally while being treated for male breast cancer. "It was surreal. One cancer was already enough, and then four weeks later, it was lung cancer too."

He vividly remembers the moment his odds were laid out: 10% chance of surviving five years. Then a PET scan revised it downward. "That hit me hard. It forced me to re-evaluate everything."

But it also galvanized him. After his initial treatments — chemotherapy, radiation, and immunotherapy — failed, biomarker testing revealed he was EGFR-positive, opening the door to targeted therapy. At the time, the drug wasn't publicly funded. That's when Angus shifted from patient to advocate.

The Emotional Weight of "Looking Fine"

Angus speaks candidly about the mental health toll of living with an "invisible" illness. "I don't look sick. There's no visual cue like a mastectomy or an ostomy bag. But the emotional burden — the scanxiety, the fatigue, the fear — it's real and constant."



He also describes the emotional disconnect of survivorship. “When your peers are dying and you’re still here, it’s complicated. There’s grief, guilt, and gratitude all at once.”

Therapy, spiritual reflection, and old 12-step wisdom help him cope. “One day at a time. Let go of resentment. Those used to sound like clichés. Now, they keep me grounded.”

What Works — and What Still Needs Work

Angus is quick to acknowledge what Canada’s healthcare system gets right: access to expensive drugs, some progress on early diagnosis, and a collaborative advocacy community. But he’s equally clear-eyed about what needs to improve:

- Delays in diagnosis and test results
- Fragmented communication across providers
- A lack of continuity that forces patients to repeat their history
- The emotional toll of poorly managed digital tools

“I’ve read scan results online that terrified me — then had to wait six weeks for an oncologist to explain them. That’s not okay.”

He also calls for improved education and consistency around biomarker testing, calling it the gateway to personalized care that’s too often delayed or overlooked.

Redefining Survivorship and the Role of Community

The landscape of lung cancer is changing — and Angus is helping shape what survivorship looks like in this new era. “Ten years ago, we didn’t talk about long-term survivorship in lung cancer. Now, people are living five, ten, even more years beyond diagnosis. But the support systems haven’t caught up.”

He believes survivorship must include robust mental health supports and reframe palliative care as a proactive resource, not just an end-of-life service.

He’s also built a strong peer support network, hosting regular Zoom calls for people with lung cancer across Canada. “Community has been a lifeline. It’s where we find understanding, connection, and purpose.”

Legacy, Advocacy, and a Message for the Future

Hope, for Angus, has evolved. What began as a hope for more time is now a hope for impact. “I want to make it better for the next person — so they don’t have to fight the same battles I did.”

He’s plays a leading role in campaigns with Canadian advocacy groups and is a vocal presence in research advisory groups, pushing for patient voices to be at the centre of care and policy decisions.

“If you have lungs, you can get lung cancer. Listen to those of us living it. And stop making us carry the guilt.”

His advice to those newly diagnosed is clear:

- Get biomarker testing and understand your treatment options
- Find a supportive care team — and a doctor who listens
- Connect with others who’ve been there
- Keep looking forward — find your reason to hope

And for decision-makers, his message is simple but powerful:

“If you have lungs, you can get lung cancer. Listen to those of us living it. And stop making us carry the guilt.”

LIVING WITH LUNG CANCER

A Conversation with Aurica Runcan

Speaking Up. Being Seen.

For Aurica Runcan, living with lung cancer is not just a medical journey, it's an ongoing act of resilience. A proud mother and grandmother based in Hamilton, Ontario, Aurica lives with purpose and determination. As someone who is Deaf, she has spent her life navigating barriers – but nothing prepared her for what it would mean to face lung cancer in a system that often struggles to communicate with people like her.

In 2012, Aurica was diagnosed with breast cancer, which she beat. A decade later, in 2022, her doctors found a spot on her right lung during routine lab work. A biopsy confirmed lung cancer. What followed was a rush of scans, tests, and appointments – all happening in a language and process that didn't fully include her.

"It didn't feel real at first," she recalls. "Everything moved so fast. But nothing was made easy – not the appointments, not the conversations. I had to fight just to understand what was happening."

When the System Doesn't Speak Your Language

From the moment of diagnosis, communication was one of the biggest barriers. Interpreters were not always booked. Visual tools were lacking. Clear, accessible written information was rare. More often than not, Aurica had to rely on her son to interpret complex, emotional medical conversations in real time – a burden that was heavy for both of them.

"He's not a professional interpreter, and things get missed. Imagine hearing you have cancer and not even being able to fully understand what that means."

These experiences weren't isolated to oncology. From pharmacies to labs, many everyday moments were made harder by systems that weren't designed with Deaf people in mind. Some staff spoke louder instead of writing things down. Others avoided eye contact altogether.

"It's your life, your health, but you feel like a bystander," she says. "It's not about hearing – it's about being understood."

What Aurica needed was simple: professional interpretation, consistent visual communication, and written summaries to review on her own time. These aren't extras. They're essential.

Living with Cancer, Not Just Through It

Treatment began with radiation, followed by chemotherapy and then briefly immunotherapy, but side effects forced her to stop treatment after six months as it was impacting her health. Since then, Aurica has moved into close monitoring every three months. Her cancer has remained stable for over a year, something she is grateful for.

But stability doesn't mean ease – her daily life looks different now. She tires more easily, takes more care with tasks that once came naturally, and lives with the shadow of recurrence.

"It's not just the treatment. It's everything after – how you eat, how you sleep, how you move through your day. It changes you."

Still, Aurica remains rooted in the small rituals that bring her comfort: cooking, cleaning, walking when she can, and caring for her space. These things keep her grounded – not just as a patient, but as a person.

"That's how I feel like myself," she says. "That's how I know I'm still here."

> **"It's your life, your health, but sometimes you feel like a bystander. It's not about hearing – it's about being understood."**

Mental Health in the Margins

The emotional impact of lung cancer hit hard. Aurica experienced a period of deep depression after her diagnosis, worsened by the absence of Deaf-accessible mental health services. The isolation was profound.

"I was crying every day. I had suicidal thoughts. I didn't know where to turn. Even finding a support group I could access felt impossible."

But connection made the difference. Through Lung Cancer Canada, Aurica found a community – one that welcomed her, offered space to share, and helped lift her out of the darkness.

"Knowing I wasn't alone changed everything. Talking to others helped me feel understood and gave me strength."

Support came from many places: her family, the Deaf community, her counsellor from Canadian Hearing Services, and her own inner resolve. Still, she wishes the healthcare system understood that mental health care – especially culturally and linguistically accessible care – is as critical as any scan or drug.

The Work of Advocacy, and the Quiet Strength of Showing Up

Aurica doesn't consider herself an advocate in the traditional sense. But by sharing her story, pushing for better communication, and participating in community support groups, she is creating change.

"I've had to speak up more than I ever expected. I've had to ask – sometimes beg – for things that should be part of everyone's care."

Her experience is a powerful reminder that true equity starts with inclusion. That if patients can't access or understand their care, they're not just at a disadvantage – they're at risk.

A Message for the System, and for the Future

When asked what she would say to health leaders in Canada, Aurica is clear: "People like me – Deaf people, immigrants, people who don't speak the system's language – we live with cancer too. We deserve care that fits us."

And for those just starting their lung cancer journey, she offers quiet, hard-won wisdom:

"Take it one day at a time. Be assertive. Don't be afraid to ask for help. And know that even with cancer, there are still good days ahead."

THE POWER OF SUPPORT

A Conversation with Scott Lanaway

From Son to Advocate: A Journey through Lung Cancer

When Scott Lanaway's phone rang in 2006, he wasn't expecting a life-altering moment. On the other end was his mother, calling with devastating news: she had been diagnosed with small cell lung cancer. She was just 56 years old.

"It came completely out of nowhere," Scott recalls. "She went in for something unrelated, and suddenly, the doctors were telling her she might only have three months to live."

Scott's world changed in an instant. The shock was immediate – and surreal. "Emotionally, I couldn't process it. My brain went into problem-solving mode: 'What do we do now?' But underneath that was disbelief. You keep hoping someone made a mistake."

There were no smartphones, no easily accessible information, and very little guidance. "She trusted her doctor. Second opinions weren't really discussed. She didn't ask questions – it just wasn't how she operated," he said. "But I felt this overwhelming need to step in, to research, to help in any way I could."

Stepping into the Role of Caregiver

As a caregiver, Scott navigated complex family dynamics to become a regular presence. He drove from Toronto to Newmarket whenever he could, showing up with coffee and a bagel, sometimes just to sit quietly beside her.

"The healthcare system has a process: you're diagnosed, then come the appointments, the chemo plan, the medications. It's a machine. But as a family, we were still emotionally reeling, just trying to catch up."

He quickly learned that caregiving wasn't always about doing or fixing — it was about being. "What she needed most wasn't advice or answers. It was normalcy. It was someone to read the paper with, to sip tea with, to feel like herself for 30 minutes."

The Caregiver's Invisible Weight

Behind those everyday moments was a crushing emotional toll. There was no roadmap, no list of resources, no acknowledgment of the burden he was carrying. "No one ever said, 'Here's how to take care of yourself. Here's support for you.' You're expected to just figure it out. It was a lonely, overwhelming place."

He tried to maintain some balance through work and occasional social outings, but even those were fraught. "Telling people your mom has terminal cancer silences the room. No one knows what to say."

A turning point came when he connected with someone who had also lost a parent to cancer. "That changed everything. Nothing was fixed, but I felt seen. That was powerful."

Strength in the Face of Fear

Diane, Scott's mother, underwent 45 rounds of chemo and brain radiation. "She was an absolute gladiator," he said. "She and my sister had shirts that said, 'Tough Cookie,' and that's exactly what she was."

But strength doesn't erase fear. "She was terrified of dying. She'd wake up screaming some nights. And watching someone you love suffer, knowing there's nothing you can do to make it better – that's the hardest part."

> **"Caregivers are the invisible lifeline in cancer care, but we're often treated as afterthoughts. That needs to change."**

Diane lived 15 months beyond her diagnosis, a full year more than expected. One moment remains etched in Scott's memory: sitting in her kitchen as she brewed tea, her shaved head catching the light. "I thought, 'She's still here, right now.' But I also knew I'd lose her soon. That moment is still clear as a bell, all these years later."

Turning Grief into Advocacy

After his mother's passing, Scott carried her memory into something greater. In 2023, he joined the Board of Lung Cancer Canada, the only national charity focused solely on lung cancer, bringing his lived experience into national conversations on care, policy, and support.

"Caregivers are the invisible lifeline in cancer care, but we're often treated as afterthoughts. That needs to change," he says. "When we fail to support caregivers, we're also failing patients."

He believes lived experience must be part of decision-making – not just stories, but strategy. "Every lung cancer experience depends on where you live, who's in your corner, and how the system works – or doesn't. The only way to close those gaps is to listen deeply and act intentionally."

Legacy, Reflection, and a New Kind of Hope

In that final year, Scott says, his mother taught him the most profound lessons: about presence, resilience, and what truly matters. "A cup of tea. A walk. A laugh. These things become everything."

Her sharp sense of humour brought unexpected lightness. "We had moments of roaring laughter right in the middle of fear and pain. It was our way of staying human, of surviving it together."

Most of all, he learned that people don't change just because they're dying. "We hope for some big final moment, but most of the time, people pass away just as they lived — complex, imperfect, and beautifully unfinished."

Today, Scott sees reasons for hope. "Through Lung Cancer Canada, I've met people living full lives with stage 4 lung cancer – that's something we didn't see 15 years ago. Early detection and better treatments are making a difference."

To Those Just Beginning This Journey

His message to other caregivers, families, and patients is simple but powerful:

"You are not alone. There's a community out there that understands what you're going through. Reach out. Ask for help. Find your people. Because they're out there. And they care."

THE POWER OF SUPPORT

A Conversation with Bonnie Leung

The Heart of the System: Nursing in Lung Cancer Carer

Bonnie Leung's journey into lung cancer nursing was unexpected. Starting in intensive care and rheumatology, oncology wasn't initially part of her plan. But when her mother was diagnosed with thymic carcinoma in 2013 — an uncommon cancer of the thymus gland — Bonnie's personal experience merged with her professional path.

As both caregiver and nurse practitioner student, Bonnie confronted the realities of cancer care: translating medical jargon; navigating the fragmented health care system; and managing fears, uncertainties and expectations. Encouraged by her mother's care team at BC Cancer, she discovered the profound difference nurses can make, especially for patients from diverse communities.

With her Chinese language skills and lived experience, Bonnie joined BC Cancer's thoracic oncology team in Vancouver, finding her true calling. "It was serendipitous – everything just aligned perfectly," she reflects.

Mentored by experts like Drs. Cheryl Ho and Janessa Laskin, Bonnie quickly realized she had found her place. "I saw what excellent care could be, and I wanted to make that the standard, not the exception. Lung cancer care is evolving fast – that's what keeps me going."

More Than a Nurse

In the often-fragmented world of cancer care, nurses like Bonnie are the heart and soul: the connective thread supporting patients from first symptoms through long-term follow-up.

"Often, patients have a lot of information to process at the most vulnerable time of their lives," Bonnie explains. "They know they can ask nurses anything, even the 'hard' or what they perceive as 'stupid' questions, and we'll listen without judgment. We learn together, side by side."

She is particularly passionate about nurse navigators, who provide crucial support while patients and caregivers wait for their first appointment with the cancer care team. Having a consistent person to address questions and concerns eases fear, shortens

wait times, and connects patients to the right care early.

"Cancer doesn't start the day you walk into the oncology clinic," Bonnie says. "It begins when people develop persistent symptoms or when told about their abnormal test results. That 'in-between' time is very distressing and no one should face it alone."

Throughout treatment, nurses remain a constant presence – administering therapies, managing side effects, and supporting patients and caregivers emotionally, practically, and spiritually. "The system simply wouldn't function without nurses."

The Emotional Weight

The deep bonds oncology nurses develop with patients are powerful, but emotionally demanding. Bonnie emphasizes the importance of self-care.

"Oncology requires a special resilience. You must care for others, but also for yourself. It's a difficult balance."

Her team creates regular spaces to debrief – safe moments to process grief and stress. "We keep pushing forward, but we need time to pause and feel." Humour, camaraderie, and even cake help. "Sometimes it's the little things that get us through tough days."

Centring Equity in Every Step of Care

Bonnie's nursing approach is rooted in equity – seeing the whole person, not just the diagnosis. She recognizes social, emotional, and practical realities shaping each patient's ability to access and tolerate treatment.

Leading a geriatric screening pilot at BC Cancer, Bonnie assesses frailty, mobility, and social risks among older adults with lung cancer to tailor sustainable care. Coordinating home supports, simplifying medications, or arranging Meals on Wheels are not extras—they are essential.

"Cancer doesn't happen in a vacuum. You can't treat the disease if the person lacks food, shelter, or support."

Yet, systemic barriers persist: people with financial means, are racialized, and have housing-insecurity face treatment obstacles unrelated to their medical condition. Bonnie has faced heart-wrenching decisions balancing best clinical practices with a patient's social realities.

"Sometimes, we hesitate to offer systemic therapy if a patient is housing insecure and can't access prescriptions or care for treatment-related adverse effects. That's not a clinical failure – it's a social one."

She's also concerned about clinical trial gaps for older adults, non-English speakers, and complex patients, who are often excluded, leaving care guidelines unrepresentative of the real world population.

> **"We hear the gaps every day but haven't always had the tools to act at a systemic level. This network can change that."**

True equity means reimagining every step, from early detection to survivorship, through the lens of who's left behind. This includes providing culturally safe care for Indigenous patients, improving rural access, and addressing stigma and bias about who "deserves" care.

"Nursing lets us see the whole picture. And when you see it, you can't ignore the inequities."

Building a Network for Change

To address these challenges, Bonnie has been part of Lung Cancer Canada's Lung Nurses Network: a community uniting oncology nurses across Canada specializing in lung cancer care – and she is encouraging her fellow colleagues across the country to join as well.

This network will foster collaboration, resource-sharing, professional growth, and emotional support. “There are strong networks for oncologists, but nurses don’t have a lung cancer-specific community. It’s time we create one.”

It will also empower nurses interested in advocacy, providing tools and training to bring patient stories to the policy table.

“We hear the gaps every day but haven’t always had the tools to act at a systemic level. This network can change that.”

Looking Ahead with Hope

Despite challenges, Bonnie is hopeful about the future. Advances like new peri-operative systemic therapy, improved screening, and earlier diagnosis are improving outcomes.

She also calls for a broader conversation on survivorship — fertility, intimacy, and quality of life — especially for younger patients and those living longer with advanced disease.

“I had an older patient ask me about intimacy, and I had no resources to offer them. That shouldn’t happen. The Lung Nurses Network can help fill those gaps.”

Words of Encouragement

To new oncology nurses, Bonnie offers:
“You won’t know everything—and that’s okay. What matters is showing up with heart and a willingness to learn.”

To patients and families:
“Connect with peer support. Ask questions. Speak up when something doesn’t feel right. Your voice is more powerful than you realize.”

And to the healthcare system:
“Keep listening. Keep striving for care that is inclusive, compassionate, and responsive to the needs of our patients.”

THE NEW FACES OF SURVIVORSHIP

A Conversation with Winhan Wong

There Isn't a Finish Line: Living with Lung Cancer – and Living Fully

At 42, Winhan Wong was healthy and active – a devoted husband and father of two school-aged children. "The day before my diagnosis, I played two hours of hockey," he recalls. A lingering cough was the only concern before a flight. "I thought I'd just get some medicine and be fine."

Instead, he was diagnosed with stage 4 lung cancer.

"When my doctor called me in and asked my daughter to wait outside, I knew something was wrong. I'd brought her thinking it was just a cough," he says. The news shocked everyone, especially since Winhan didn't fit the typical lung cancer profile.

"The biggest misconception is that lung cancer only affects smokers. Even the first ER doctor assumed I smoked. But I've never smoked a day in my life. I felt like I had to prove it. The reality is anyone with lungs can get lung cancer."

Navigating a Complex System

Winhan's cancer was ALK-positive, making him eligible for targeted therapy – a daily oral pill that transformed his treatment and quality of life. But accessing these drugs was far from straightforward.

"We were told the drug was approved on a Friday. By Monday, it was denied. The out-of-pocket cost? Over $10,000." With persistence, advocacy, and his oncologist's support, Winhan secured access to crizotinib. "The worst side effect was some diarrhea, but I didn't miss work or school events. I'm incredibly grateful for that normalcy."

After four years, he transitioned to alectinib, facing more insurance hurdles. Thanks to the Trillium Drug Benefit program, he got coverage and continued living fully.

Subsequent therapies presented ongoing challenges accessing publicly unfunded drugs, including brigatinib, which worked briefly before progression. Fortunately, clinical trials for next-generation drugs offered renewed

hope, providing effective treatment with minimal side effects.

"Access remains fragile. The stress of potential out-of-pocket costs is always in the back of my mind."

The Long Haul of Survivorship

Nearly nine years post-diagnosis, Winhan defies expectations, yet survivorship isn't what many imagine.

"People picture ringing a bell, high-fives, and being 'done.' But there isn't a finish line. It's about learning to live with uncertainty."

He undergoes scans every two months. "You hope the results are good, but you know the cancer will likely return – you just don't know when. That 'scanxiety' shapes how I live."

This uncertainty has shifted his priorities. "I try to do more with my kids — solo trips, just us — and live in the moment."

Winhan keeps his diagnosis private from his mother, choosing to protect her from worry unless things worsen. "She lives a couple of blocks away, but she still doesn't know even after 8.5 years."

Professionally, he's lost clients upon disclosure, reflecting ongoing stigma. "People assume if you have cancer, you're sick. But honestly? I could probably outrun most of them. I just have this label."

Identity and Representation

"As a young, non-smoking Asian man, I'm not the 'typical' face of lung cancer," Winhan says. "I have heard ALK-positive lung cancer often shows up in young Asian people, but I've met people of all races and ages. It really can happen to anyone with lungs."

This drives his commitment to breaking stigma and broadening public understanding.

Finding Hope and Paying It Forward

Early support from Lung Cancer Canada connected Winhan to advocate Anne Marie Cerato and the ALK-positive Facebook group. "That community has been huge. I try to and have met new members in person, so they know they're not alone. Unfortunately, Anne Marie has since passed but I do think of her a lot and want to continue her legacy of helping others."

He credits science for hope but criticizes the system's slow pace. "The drugs exist and work, but access is delayed. If I'd had to rely on chemotherapy, my quality of life would be totally different. I might have had to stop working."

He highlights the unseen costs: "The system sees the price tag on drugs but not the cost of me missing work or what it means for my family."

Winhan's Message to the Community

"To those newly diagnosed: it's terrifying, I know. But there's a path forward. You're not alone. Ask questions. Let people help. Do your own research. Advocate for yourself. Not every oncologist is an expert in your specific lung cancer type, so don't be afraid to seek second opinions. Your life depends on it."

"Lung cancer doesn't discriminate by age, race, or lifestyle. But with the right treatment, you can continue to live a life that is meaningful for years to come."

THE NEW FACES OF SURVIVORSHIP

A Conversation with Arta & Dritero Shala

Facing Lung Cancer Together

For Arta and Dritero Shala, life had been stable and full of simple joys: a close-knit family, a daughter thriving in university, and fulfilling careers. As immigrants who rebuilt their lives in Canada after fleeing war in Kosovo 25 years ago, they believed their greatest challenges were behind them. But in December 2024, everything changed.

The day their daughter returned home for winter break was when Dritero first felt unwell. “It was just a dry cough at first,” Arta recalled. “We thought it was a cold and hoped it would pass.”

But the cough worsened rapidly. “By December 12th, he told me, ‘I can’t believe how short of breath I am.’ That’s when I knew something was wrong.”

After being seen by his family physician and turned away from two fully booked medical imaging clinics, a third finally saw him, and Dritero was diagnosed with pneumonia and prescribed antibiotics. But by Sunday evening, Dritero’s fingers had turned blue – Arta called an ambulance and rushed him to the ER.

The next day, Dritero was admitted to ICU, requiring intubation and mechanical ventilation as fluid overwhelmed both his lungs and the sac around his heart. “It felt like something from a TV drama – surreal and terrifying. I wondered, was I saying goodbye?”

Then, a crushing discovery: cancer cells found in the drained fluid. “Our world shattered,” Arta said. “I paced the hospital halls, unable to speak. It was like nothing I’d ever imagined.”

Despite the shock, Dritero’s courage shone. “He looked at us and said, ‘We’ll beat this. I have the best people around me.’ That strength gave me hope.”

A Diagnosis That Defied Assumptions

At 52, Dritero was fit, active, never smoked, and rarely drank. This made the diagnosis even harder for their family and friends to grasp.

“People still think lung cancer only happens to smokers,” Arta said. “We were stunned. His routine blood test four months earlier was normal. My own father died of lung cancer, but he was a lifelong smoker. Dritero's case was different."

Their oncologist revealed the diagnosis: stage IV lung cancer with a RET fusion mutation — a rare genetic driver common among non-smokers. Yet there was hope: targeted therapy was available.

The $19,000 Shock and the System That Caught Them

Hope collided with harsh reality when their pharmacy told them the targeted therapy cost $19,000 per month, and their insurance wouldn't cover it.

"I thought it was per year," Arta said. "But per month? I broke down. What do you do? Sell your house? And even then, it would only buy a couple of years of treatment. It was terrifying."

For days, Arta kept the news from Dritero. "I didn't sleep," she said. "He could tell something was wrong."

Thankfully, Ottawa's oncology pharmacy team stepped in with a reimbursement coordinator who helped secure financial aid, a bridging program, and expedited treatment access.

"We were incredibly lucky," Arta said. "But what about people without a caregiver? Without language skills or system knowledge? Navigating this while facing cancer is overwhelming."

The Caregiver's Load: "You Give Hope to Everyone but Yourself"

As a natural caregiver, Arta found herself managing logistics and emotions – for Dritero, their daughter, and everyone around them.

"You can't fall apart," she said. "You have to hold it together – at work, at home, in the hospital. I gave hope to everyone except myself."

She described the unseen toll: "You're expected to be the rock, the planner, the comforter, all while your soul is breaking. Crying in the shower was my only release."

Community support was vital. Friends dropped off meals, shoveled snow, and offered space for Dritero to share if he wished, without pressure. Their sister-in-law helped navigate the health care system, while Arta's 86-year-old mother helped run the household, enabling Arta to keep working.

Yet the emotional grief lingered. "It's not just fear but mourning the life we had — the freedom to make spontaneous plans, travel, visit our daughter without scheduling around appointments."

Living With Lung Cancer — and Living Fully

Today, Dritero is doing well. His tumour has shrunk on targeted therapy; he's back to full-time work and socializing weekly. But anxiety around tests and scans remains ever-present.

"It's always in the back of my mind," he said. "But I don't let it stop me. Family, friends, and my work team keep me going."

Their daughter, now in her second year of university, has grown resilient. "She struggled at first — angry and scared. Although at the beginning we tried to shield her from the harsh reality, we quickly realized we must be honest with her, even about diagnosis, prognosis, wills and power of attorney. She's handled it with grace."

Looking Forward: Hope and Advocacy

"Targeted therapy saved my husband's life," Arta said. "Yet we almost couldn't access it. No one should have to choose between treatment and financial ruin."

She advocates for better access, clearer communication, and centralized health records like Denmark's unified system. "We shouldn't be chasing paperwork while our lives fall apart."

To newcomers, caregivers, and families starting this journey, their message is clear:

"Don't give up. Believe in yourself," said Dritero. "Stay disciplined. Be resourceful. Share your story — you never know who's walking the same path."

"And to caregivers," Arta added, "look after yourself. You can't pour from an empty cup. Reach out. Ask for help. You're not alone."

TURNING HOPE INTO ACTION

A Conversation with Dr. Alison Wallace

Time Is of the Essence: Equity in Lung Cancer Care

For Dr. Alison Wallace, lung cancer care is not just a specialty — it's a calling. Based in Halifax, Nova Scotia, she serves as a thoracic surgeon treating patients throughout the province and neighbouring Prince Edward Island, where lung cancer referrals funnel to a dedicated team of only five surgeons. Beyond the operating room, Dr. Wallace is an associate professor at Dalhousie University, a national research leader, and a tireless advocate for equitable lung cancer care – especially for rural and underserved populations.

"My goal is to improve outcomes for all patients," she explains, "but to do that, we must confront the barriers faced by those living far from urban centres or grappling with systemic disadvantages."

Her dual role as frontline surgeon and researcher provides her with a unique vantage point to pinpoint gaps that affect patient outcomes. With 60% of Nova Scotia's population residing in rural areas, Dr. Wallace often witnesses patients making arduous, multi-hour trips for diagnostics and care.

"It's not unusual for patients to drive three or four or five hours each way multiple times just to get their tests done. That alone can delay treatment or cause people to give up entirely. That's a heavy burden, and it's deeply inequitable."

The Reality of Lung Cancer in Atlantic Canada

Dr. Wallace's focus on equity stems from both data and lived realities. Atlantic Canada faces lung cancer rates roughly 30% higher than the national average and has the highest proportion of stage 4 diagnoses.

She has identified a concerning pattern she terms the Atlantic Canadian Cancer Syndrome: patients presenting with multiple primary cancers linked to a limited gene pool (founder effect) and environmental exposures such as radon and arsenic.

"One in three homes in Nova Scotia has radon levels exceeding Health Canada's recommended limit," Dr. Wallace says. "Combined with other environmental factors, it paints a troubling picture. Comparing this region to my hometown Vancouver, the gaps in prevention and health promotion are stark. Social determinants of health impact everything we see here."

Uncovering Gaps in Care

Beyond disease biology, Dr. Wallace highlights logistical barriers:

"A typical lung cancer workup requires multiple tests, such as CT scans, PET scans, biopsies, and pulmonary function testing, often at different locations. For rural patients, this means exhausting travel and added expenses, creating inequities in care."

The disparity is even starker for Indigenous communities:

"Despite a significant Indigenous population, very few show up in our clinics. We know lung cancer disproportionately affects these communities, so this absence signals a broken system."

Equity-Driven Research Initiatives

Dr. Wallace leads two key projects addressing care disparities:

1. **POWR Study:**
   Examining nearly 10,000 lung cancer surgeries nationwide, this study revealed women are diagnosed earlier and have better outcomes post-surgery. These insights are driving exploration into sex-specific care pathways to optimize treatments.
2. **BREATHE WELL Program:**
   A prehabilitation initiative focusing on nutrition, smoking cessation, physical activity, and mental wellness, tailored to meet patients "where they are." This program is being culturally adapted for Indigenous communities with input from local partners to increase engagement and improve outcomes.

Early data shows participants experience fewer complications and greater confidence entering surgery.

Advocacy for Systemic Change

Dr. Wallace stresses that research alone isn't enough: "We need urgent system-level reforms — from screening and diagnostics to treatment timelines. I've seen patients in New York who have their lung cancer workup completed and start treatment within one week. In Canada, it can take months. People can die during those delays."

She advocates for broader screening criteria that reflect emerging lung cancer risk profiles beyond age and smoking history, particularly as non-smoker diagnoses rise.

She points to inefficiencies in resource allocation:

"PET scan slots are limited and shared with other cancers like prostate, which have different urgency levels. Lung cancer patients need prioritization because their disease is immediately life-threatening."

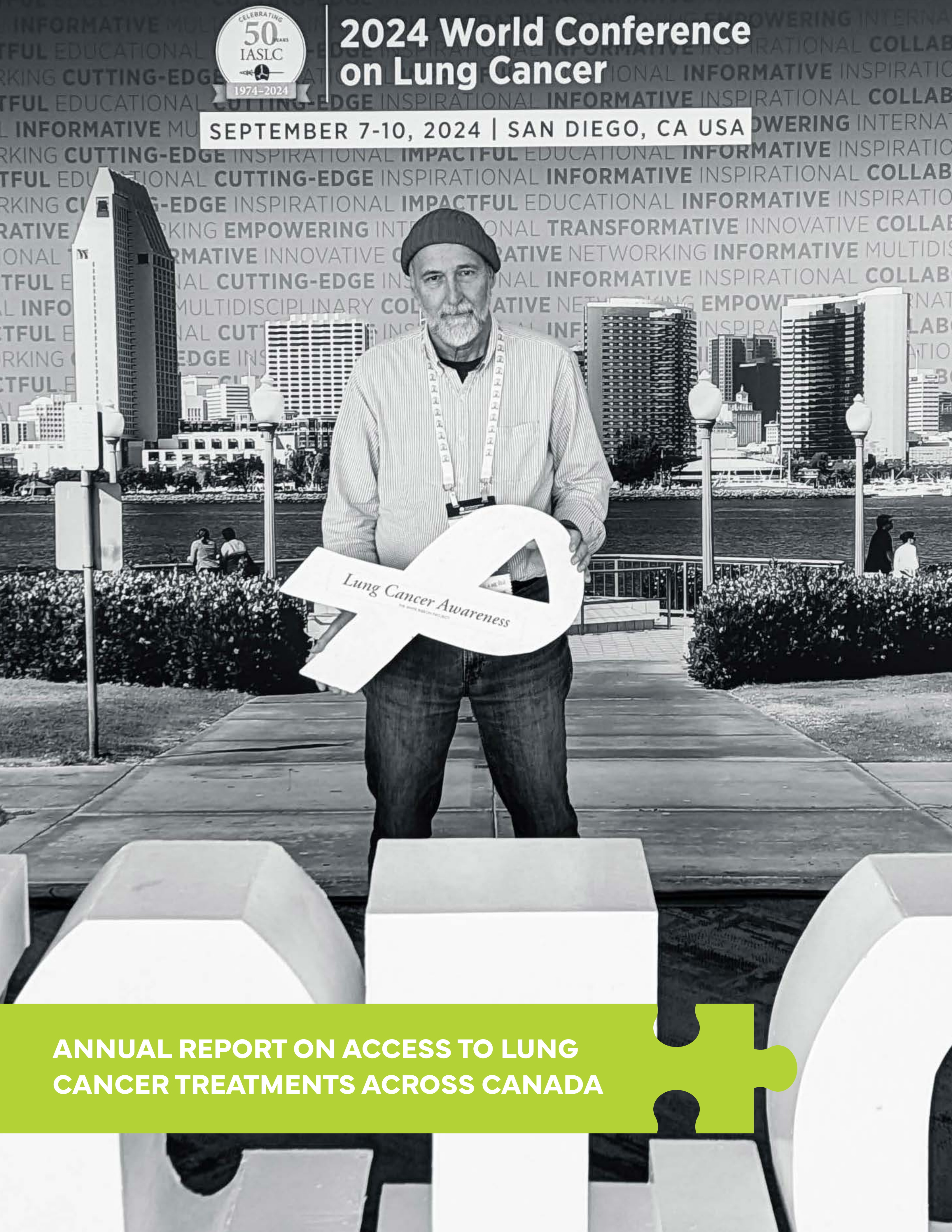
> **"We must deliver broader screening, faster diagnostics, and targeted support for the communities most in need. No one should have to fight cancer and the system."**

She also calls for better infrastructure to support travel funding, culturally safe care, and centralized health records – so patients don't have to navigate a fragmented system while battling cancer.

Environmental risk factors like radon and vaping are also priorities in her advocacy.

A Clear Call to Action

Dr. Wallace's message to policymakers is unequivocal: "Equity in lung cancer care means urgency and action. We must deliver broader screening, faster diagnostics, and targeted support for the communities most in need. No one should have to fight cancer and the system. Let's treat lung cancer with the seriousness it deserves and give every Canadian a real chance."



ANNUAL REPORT ON ACCESS TO LUNG CANCER TREATMENTS ACROSS CANADA

ANNUAL REPORT ON ACCESS TO LUNG CANCER TREATMENTS ACROSS CANADA

The following tables provide a snapshot of the current availability of lung cancer treatments across Canada, illustrating how therapies move through the system—from Health Canada approval to provincial coverage.

The data reveals the lengthy process many treatments endure before becoming accessible to those in need. While Health Canada approvals often follow those of the Food and Drug Administration (FDA) in the U.S., securing provincial coverage — which is vital for ensuring patient access — can take significantly longer. This lag creates disparities, with some provinces offering newer, life-saving treatments much sooner than others.

These tables highlight the urgent need to shorten these timeframes and ensure that innovative lung cancer therapies are made available equitably across Canada. Timely access to treatment can be a matter of life or death, and every Canadian, regardless of location, deserves the best possible care. The data reinforces the necessity for ongoing advocacy to accelerate drug approvals and achieve consistent coverage nationwide, ensuring that no one is left behind.

TABLE 1

Status of Canada Drug Agency (CDA) Drug Recommendations (Within the Last 5 Years)

Drug: Generic Name (Brand Name)	**Indication**	**Health Canada Approval Date**	**CDA Reimbursement Status** (Availability in all provinces EXCEPT QC)	**INESSS Reimbursement Status** (Availabity in QC only)	**Phase Data Used**
alectinib (Alecensa®) - adjuvant ALK	As adjuvant treatment following tumour resection in adult patients with Stage IB - IIIA ALK-positive non-small cell lung cancer (NSCLC)	June 27, 2024	Oct 30, 2024 - Reimburse with Conditions	July 2, 2025 - Reimburse with Conditions	3
amivantamab (Rybrevant®)	For the treatment of adult patients with locally advanced or metastatic NSCLC with EGFR Exon 20 insertion mutations whose disease has progressed on, or after platinum-based chemotherapy (CHRYSALIS)	March 30, 2022	March 20, 2023 - Reimburse with Conditions	May 25, 2023 -Do Not Reimburse	1
amivantamab (Rybrevant®) w/ Chemo	In combination with carboplatin and pemetrexed for the first-line treatment of adult patients with locally advanced or metastatic non-small cell lung cancer with EGFR exon 20 insertion mutations	June 28, 2024	Jan 29, 2025 - Reimburse with Conditions	February 5, 2025 - Reimburse with Conditions	3
amivantamab (Rybrevant®) 2nd line	in combination with carboplatin and pemetrexed for the treatment of patients with locally advanced (not amenable to curative therapy) or metastatic NSCLC with EGFR Exon 19 deletions or Exon 21 L858R substitution mutations, whose disease has progressed on or after treatment with osimertinib (MARIPOSA-2)	January 13, 2025	Currently Under Review	Currently Under Review	3

● New/Updated for 2025

**Current as of November 1, 2025*

TABLE 1 (Continued)

Drug: Generic Name (Brand Name)	Indication	Health Canada Approval Date	CDA Reimbursement Status (Availability in all provinces EXCEPT QC)	INESSS Reimbursement Status (Availabiity in QC only)	Phase Data Used
amivantamab & lazertinib (Lazcluze® & Rybrevant®)	lazertinib in combination with amivantamab is indicated for the first-line treatment of adult patients with locally advanced (not amenable to curative therapy) or metastatic NSCLC with EGFR exon 19 deletions or exon 21 L858R substitution mutations (MARIPOSA)	March 6, 2025	July 21, 2025 - Reimburse with Conditions	Currently Under Review	3
atezolizumab (Tecentriq®) - SCLC	For the first-line treatment of patients with extensive stage small cell lung cancer (ES-SCLC) in combination with a platinum-based chemotherapy and etoposide. ** subcutaneous (SC) formula of atezolizumab is also approved for this indication**	August 8, 2019	September 1, 2022 - Reimburse with Conditions	February 5, 2025 - Reimburse	3
atezolizumab (Tecentriq®) - Adjuvant	For adjuvant treatment following resection and platinum-based chemotherapy for patients with stage II to IIIA NSCLC whose tumours have PD-L1 expression on ≥ 50% of tumour cells. **subcutaneous (SC) formula of atezolizumab is also approved for this indication**	January 14, 2022	September 1, 2022 - Reimburse with Conditions	April 13, 2023 - Reimburse with Conditions	3
atezoliumab (Tecentriq®) - 1st line high PD-L1	Indicated as monotherapy for first-line treatment of patients with metastatic NSCLC whose tumours have high PD-L1 expression (PD-L1 stained greater than or equal to 50% of TCs or PD-L1 stained tumour-infiltrating immune cells covering greater than or equal to 10% of the tumour area), as determined by a validated test and who do not have EGFR or ALK genomic tumour aberrations. (IMscin001, IMscin002, IMpower110)	March 1, 2021	Currently Under Review	Currently Under Review	3
Atezolizumab & Bevacizumab (Tecentriq® & Avastin®)	For the treatment of metastatic EGFR and/or ALK positive non-squamous non-small cell lung cancer in patients who have progressed on treatment with targeted therapies.	May 24, 2019	July 3, 2020 - Not Reimbursed	Not Reimbursed	3
cemiplimab (Libtayo®)	As monotherapy for first-line treatment of locally advanced NSCLC expressing PD-L1 (Tumour Proportion Score [TPS] ≥ 50%) with no EGFR, ALK, or ROS1 aberrations	June 2, 2022	June 2, 2022 - Reimburse with Conditions	Aug 14, 2025 - Reimburse with Conditions	3
cemiplimab (Libtayo®) w/ chemo	In combination with platinum-based chemotherapy for the first line treatment of adult patients with NSCLC whose tumours have no EGFR, ALK or ROS1 aberrations and is: locally advanced where patients are not candidates for surgical resection or definitive chemoradiation, or metastatic NSCLC.	April 27, 2023	May 2, 2024 - Reimburse with Conditions	Aug 14, 2025 - Reimburse with Conditions	3

● New/Updated for 2025

**Current as of November 1, 2025*

TABLE 1 (Continued)

Drug: Generic Name (Brand Name)	**Indication**	**Health Canada Approval Date**	**CDA Reimbursement Status** (Availability in all provinces EXCEPT QC)	**INESSS Reimbursement Status** (Availabiity in QC only)	**Phase Data Used**
"dabrafenib (Tafinlar®) & trametinib (Mekinist®)"	For the treatment of patients with metastatic NSCLC with a BRAF V600 mutation and who have not received any prior anti-cancer therapy for metastatic disease.	May 18, 2018	May 28, 2021 - Reimburse with Conditions	May 27, 2021 - Do Not Reimburse	2
durvalumab (Imfinzi®) ES-SCLC	First-line treatment of adult patients with extensive-stage small cell lung cancer (ES-SCLC) in combination with etoposide and either carboplatin or cisplatin	September 21, 2020	July 27, 2021 - Reimburse with Conditions	July 6, 2023 - Do Not Reimburse	3
durvalumab (Imfinzi®) LS-SCLC	durvalumab for limited-stage small cell lung cancer whose disease has not progressed following platinum-based chemoradiotherapy (ADRIATIC)	April 8, 2025	August 27, 2025 - Reimburse with Conditions	Aug 14, 2025 - Reimburse with Conditions	3
durvalumab (Imfinzi®) - periadjuvant	In combination with chemotherapy as neoadjuvant treatment, followed by durvalumab as monotherapy after surgery, for patients with resectable NSCLC and no known EGFR or ALK mutations. (AEGEAN)	Currently Under Review	Currently Under Review	Currently Under Review	3
durvalumab & tremelimumab (Imfinzi® & Imjudo®)	Durvalumab in combination with tremelimumab and platinum-based chemotherapy is indicated for the first-line treatment of patients with metastatic NSCLC with no sensitizing EGFR or ALK mutations. (POSEIDON)	April 10, 2025	June 17, 2025 - Reimburse with Conditions	July 2, 2025 - Reimburse with Conditions	3
entrectinib (Rozlytrek®) - ROS1	For the first-line treatment of adult patients with ROS1-positive locally advanced or metastatic non-small cell lung cancer	May 5, 2020	January 27, 2021 - Reimburse with Conditions	August 18, 2021 - Reimburse with Conditions	1 & 2
entrectinib (Rozlytrek®) - NTRK	For the treatment of adult patients with unresectable locally advanced or metastatic extracranial solid tumours, including brain metastases, that have a NTRK gene fusion without a known acquired resistance mutation, and with no satisfactory treatment options.	February 10, 2020	November 21, 2022 - Reimburse with Conditions	December 14, 2022 - Do Not Reimburse	1 & 2
larotrectinib (Vitrakvi®)	For the treatment of adult and pediatric patients with solid tumours that have a NTRK gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have no satisfactory treatment options	July 10, 2019	September 13, 2021 - Reimburse with Conditions	July 7, 2021 - Do Not Reimburse	1 & 2
"lorlatinib (Lorbrena®) 1st line"	For the first-line treatment of adult patients with ALK-positive locally advanced (not amenable to curative therapy) or metastatic NSCLC	June 7, 2021	March 17, 2022 - Reimburse with Conditions	July 6, 2023 - Reimburse with Conditions	3
lurbinectedin (Zepzelca®)	Treatment of adult patients with Stage III or metastatic small cell lung cancer (SCLC) who have progressed on or after platinum-containing therapy.	September 29, 2021	Currently Under Review	Aug 16, 2023 - Do Not reimburse	2

● New/Updated for 2025

**Current as of November 1, 2025*

TABLE 1 (Continued)

Drug: Generic Name (Brand Name)	**Indication**	**Health Canada Approval Date**	**CDA Reimbursement Status** (Availability in all provinces EXCEPT QC)	**INESSS Reimbursement Status** (Availabiity in QC only)	**Phase Data Used**
nivolumab (Opdivo®)	For neoadjuvant treatment of adult patients with resectable NSCLC (tumours ≥4cm or node positive) when used in combination with platinum-doublet chemotherapy.	August 23, 2022	April 18, 2023 - Reimburse with Conditions	September 27, 2023 - Reimburse with conditions	3
nivolumab-ipilimumab (Opdivo® - Yervoy®)	Nivolumab, in combination with ipilimumab and 2 cycles of platinum-based chemotherapy for the first-line treatment of patients with metastatic or recurrent NSCLC with no EGFR or ALK genomic tumour aberrations	August 6, 2020	March 4, 2021 - Reimburse with Conditions	November 9, 2022 - Reimbursed	3
nivolumab-ipilimumab (Opdivo-Yervoy®) - MPM	OPDIVO, in combination with ipilimumab, is indicated for the treatment of adult patients with unresectable malignant pleural mesothelioma (MPM) who have not received prior systemic therapy.	June 2, 2021	August 4, 2021 - Reimburse with Conditions	March 2, 2022 - Reimbursed	3
nivolumab (Opdivo®) - periadjuvant	Neoadjuvant nivo in combination with chemotherapy followed by adjuvant nivolumab for patients with resectable stage II-IIIB NSCLC (CheckMate 77T)	August 24. 2022	April 18, 2023 - Reimburse with Conditions	Currently Under Review	3
osimertinib (Tagrisso®) - adjuvant	Osimertinib is indicated as adjuvant therapy after tumour resection in patients with stage IB-IIIA NSCLC whose tumours have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations	January 3, 2021	January 10, 2022 - Reimburse with Conditions	November 9, 2022 - Reimbursed	3
osimertinib (Tagrisso®) - stage 3 unresectable	For the treatment of patients with locally advanced, unresectable (stage III) NSCLC whose tumours have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations (either alone or in combination with other EGFR mutations) and whose disease has not progressed during or following platinum-based chemoradiation therapy (LAURA)	May 22, 2025	September 15, 2025 - Reimburse with Conditions	Currently Under Review	3
osimertinib (Tagrisso®) w/ chemo	In combination with pemetrexed and platinum-based chemotherapy for the first-line treatment of patients with locally advanced or metastatic NSCLC whose tumours have EGFR exon 19 deletions or exon 21 (L858R) substitution mutations. (FLAURA2)	July 12, 2024	October 3, 2024 - Reimburse with Conditions	Currently Under Review	3
pembrolizumab (Keytruda®) - adjuvant Stage I-IIIA	As monotherapy for the adjuvant treatment of adult patients with Stage IB, II, or IIIA NSCLC who have undergone complete resection and platinum-based chemotherapy. (KEYNOTE 091)	April 19, 2023	January 30, 2025 - Reimburse with Conditions	April 10, 2025 - Do Not Reimburse	3

● New/Updated for 2025

**Current as of November 1, 2025*

TABLE 1 (Continued)

Drug: Generic Name (Brand Name)	Indication	Health Canada Approval Date	CDA Reimbursement Status (Availability in all provinces EXCEPT QC)	INESSS Reimbursement Status (Availabiity in QC only)	Phase Data Used
pembrolizumab (Keytruda®) - MPM	In combination with pemetrexed and platinum chemotherapy, for the first-line treatment of adult patients with unresectable advanced or metastatic malignant pleural mesothelioma (IND227)	April 22, 2025	July 21, 2025 - Reimburse with Conditions	Aug 14, 2025 - Reimburse with Conditions	2 & 3
pembrolizumab (Keytruda®) - perioperative Stage II-IIIB	For treatment of resectable stage II, IIIA, or IIIB NSCLC in combination with platinum containing chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment (KEYNOTE 671)	February 11, 2025	April 4, 2025 - Reimburse with Conditions	May 22, 2025 - Do Not Reimburse	3
pralsetinib (Gavreto®)	For the treatment of adult patients with RET fusion-positive locally advanced unresectable or metastatic NSCLC	July 21, 2021	September 29, 2022 - Reimburse with Conditions	May 25, 2023 - Reimburse with Conditions	1 & 2
repotrectinib (Augtyro®)	Locally advanced or metastatic ROS 1-positive NSCLC	May 7, 2025	Not Yet Filed	Not Yet Filed	1 & 2
selpercatinib (Retevmo®)	Indicated as monotherapy for the treatment of metastatic RET fusion-positive NSCLC in adult patients	June 15, 2021	May 16, 2022 - Reimburse with Conditions	May 25, 2023 - Reimburse with Conditions	1 & 2
sotorasib (Lumakras®)	For the treatment of adult patients with KRAS G12C-mutated locally advanced (not amenable to curative therapy) or metastatic NSCLC who have received at least one prior systemic therapy	September 10, 2021	February 29, 2024 - Not Reimbursed	March 6, 2024 - Reimburse with Conditions	2 & 3
tarlatamab (Imdelltra®)	For the treatment of adult patients with extensive stage small cell lung cancer with disease progression on or after at least two prior lines of therapy including platinum-based chemotherapy.	September 11, 2024	February 28, 2025 - Reimburse with Conditions	May 22, 2025 - Do Not Reimburse	2
tepotinib (Tepmetko®)	For treatment of adult patients with locally advanced unresectable or metastatic NSCLC harbouring MET exon 14 skipping alterations.	May 27, 2021	August 24, 2022 - Do Not Reimburse	July 6, 2023 - Reimburse with Conditions	2
pembrolizumab (Keytruda®) - MPM	In combination with pemetrexed and platinum chemotherapy, for the first-line treatment of adult patients with unresectable advanced or metastatic malignant pleural mesothelioma (IND227)	April 22, 2025	July 21, 2025 - Reimburse with Conditions	Aug 14, 2025 - Reimburse with Conditions	2 & 3

● New/Updated for 2025

**Current as of November 1, 2025*

TABLE 2

Dates of Provincial Drug Coverage (Within The Last 5 years)

Drug Name	BC	AB	SK	MB	ON	QC	NS	NB	NL	PEI	NIHB
alectinib adjuvant	Not Funded	August 27, 2025	August 1, 2025	Not Funded	September 23, 2025	July 2, 2025	August 1, 2025	Not Funded	Not Funded	Not Funded	May 20, 2025
amivantamab EGFR Ex20	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
atezolizumab adjuvant	September 1, 2023	June 5, 2023	June 1, 2023	June 6, 2023	July 5, 2023	April 13, 2023	July 27, 2023	July 13, 2023	July 4, 2023	June 13, 2024	Not Funded
atezolizumab SCLC	June 1, 2023	October 20, 2022	March 1, 2023	February 21, 2023	March 10, 2023	April 13, 2022	July 27, 2023	April 19, 2023	October 1, 2024	June 13, 2024	Not Funded
atezolizumab - subcutaneous (SC) formula	July 1, 2025	Not Funded	April 1, 2025	May 1, 2025	April 30, 2025	February 5, 2025	January 1, 2025	March 21, 2025	Not Funded	May 19, 2025	Not Funded
brigatinib - 1st line ALK-positive	June 1, 2022	February 18, 2022	March 1, 2022	June 1, 2022	February 10, 2022	February 2, 2022	July 1, 2022	April 29, 2022	October 17, 2022	September 26, 2022	February 18, 2022
cemiplimab (PD-L1 ≥ 50%)	August 1, 2025	Not Funded	June 1, 2025	Not Funded	May 7, 2025	August 13, 2025	July 9, 2025	Not Funded	April 1, 2025	Not Funded	Not Funded
cemiplimab w/ chemo	August 1, 2025	August 27, 2025	June 1, 2025	Not Funded	May 7, 2025	August 13, 2025	July 9, 2025	Not Funded	April 1, 2025	Not Funded	Not Funded
crizotinib (ROS 1)	July 1, 2020	December 15, 2020	July 1, 2023	January 21, 2021	December 4, 2020	April 23, 2020	January 1, 2021	July 10, 2020	May 1, 2020	January 23, 2023	July 9, 2021
dabrafenib & trametinib BRAF V600	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
durvalumab 1st line ES-SCLC	October 1, 2022	June 15, 2022	July 6, 2022	July 20, 2022	July 22, 2022	July 6, 2022	July 20, 2022	August 3, 2022	October 1, 2022	April 3, 2023	Not Funded
entrectinib - ROS1	April 1, 2022	January 21, 2022	November 1, 2021	November 25, 2021	December 23, 2021	August 18, 2021	November 30, 2021	October 14, 2021	May 24, 2022	December 28, 2022	October 27, 2021
entrectinib - NTRK	September 1, 2023	April 1, 2024	May 1, 2023	August 24, 2023	May 16, 2023	Not Funded	October 1, 2023	June 26, 2023	October 1, 2023	June 4, 2024	May 19, 2023
larotrectinib	September 1, 2023	February 16, 2024	December 1, 2022	April 1, 2023	February 24, 2023	December 14, 2022	July 1, 2023	May 23, 2023	August 30, 2023	January 22, 2024	January 23, 2023
lorlatinib 1st line	May 1, 2024	August 1, 2023	August 1, 2023	December 21, 2023	July 17, 2023	July 6, 2023	October 1, 2023	September 28, 2023	January 4, 2024	November 27, 2023	September 1, 2023
lurbinectedin	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
nivolumab neo-adjuvant NSCLC	February 1, 2024	August 14, 2023	October 1, 2023	October 5, 2023	September 13, 2023	September 27, 2023	October 1, 2023	September 29, 2023	May 1, 2024	March 25, 2024	Not Funded

**Current as of November 1, 2025*

TABLE 2 (Continued)

Drug Name	BC	AB	SK	MB	ON	QC	NS	NB	NL	PEI	NIHB
nivolumab MPM	May 1, 2022	April 1, 2022	May 1, 2022	April 1, 2022	June 7, 2022	March 2, 2022	August 1, 2022	June 23, 2022	June 1, 2022	December 1, 2022	Not Funded
nivolumab - ipilimumab 1st line NSCLC	May 1, 2022	April 1, 2022	May 1, 2022	April 1, 2022	June 15, 2022	November 9, 2022	August 1, 2022	June 23, 2022	June 5, 2022	December 1, 2022	Not Funded
osimertinib - 1st line EGFR	January 1, 2020	April 10, 2020	March 1, 2020	April 2, 2020	January 10, 2020	December 18, 2019	May 1, 2020	March 19, 2020	February 20, 2020	February 14, 2022	February 1, 2020
osimertinib -adjuvant EGFR	February 1, 2023	January 13, 2023	February 1, 2023	May 18, 2023	November 15, 2022	November 9, 2022	March 1, 2023	February 27, 2023	September 1, 2023	November 14, 2023	January 1, 2023
osimertinib w/ chemo	September 1, 2025	Not Funded	May 1, 2025	April 1, 2025	July 4, 2025	Not Funded	May 1, 2025	May 26, 2025	May 30, 2025	Not Funded	April 16, 2025
pembrolizumab - adjuvant	Not Funded	Not Funded	June 1, 2025	Not Funded	June 20, 2025	Not Funded	July 1, 2025	October 1, 2025	August 1, 2025	Not Funded	Not Funded
pembrolizumab - perioperative	Not Funded	Not Funded	August 1, 2025	Not Funded	July 23, 2025	Not Funded	July 1, 2025	October 1, 2025	August 1, 2025	Not Funded	Not Funded
pembrolizumab - MPM	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
pralsetinib	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
selpercatinib	September 1, 2023	August 14, 2023	September 1, 2023	August 24, 2023	July 31, 2023	May 25, 2023	November 1, 2023	September 18, 2023	December 11, 2023	May 21, 2024	June 15, 2023
sotorasib	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	March 6, 2024	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
tarlatamab	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded
tepotinib	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded	July 6, 2023	Not Funded	Not Funded	Not Funded	Not Funded	Not Funded

**Current as of November 1, 2025*

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Lung Cancer Canada extends its heartfelt gratitude to the dedicated volunteers and advocates who contributed to this report.

To those with lived experience, thank you for sharing your stories of hope and resilience, which continue to inspire and uplift the lung cancer community. To the members of our Board of Directors and Medical Advisory Committee, our deepest appreciation for sharing your expertise, perspectives, and unwavering support.

Your collective efforts have made this report possible, and we are truly grateful for your commitment to improving the lives of those affected by lung cancer.

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Patient Advocate

Judy Hollingsworth
Patient Advocate

Scott Lanaway
Caregiver Advocate

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THANK YOU!

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