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**Q1** You are an established thoracic radiologist and became Second Vice-President of the European Society of Radiology (ESR) last year. Looking back, what key professional experiences or decisions most shaped your journey into European radiology leadership?

I think that one of the best decisions I made in my professional career was to engage in ESR activities. I was first involved in the European Society of Thoracic Imaging (ESTI), since I'm a thoracic radiologist. For instance, I would participate in rating the abstracts and evaluating the sessions, and take part in many ESTI meetings, giving lectures. When you give a lecture, you are the first one to benefit, because you prepare and you learn.

My colleagues at the ESTI and I also built a lung cancer screening certification programme. It was a collaborative effort because as early as 2019, we had the feeling that we would go for large population screening, which requires the training of a large number of radiologists.

Having some responsibilities within the ESR was not a long-term plan. I did not anticipate being asked to present my application to become Chair of Communication and Interdisciplinary Affairs, which I accepted, and then to apply for vice presidency, which I also accepted.

I think that what we are doing at the level of the ESR is very important; for instance, the role of advocacy, where we are trying to convince the European Parliament to recommend that member states test the feasibility of lung cancer screening.

For all these reasons, I think it was a very good decision to engage in ESR activities.

**Q2** As lead of the SOLACE project in France, you are working at the forefront of lung cancer screening implementation. How can the European Congress of Radiology (ECR) 2026 serve as a catalyst for translating screening research into sustainable, standardised programmes across different European healthcare systems?

At ECR 2026, we had two very important sessions dedicated to lung cancer screening. One was the EIBIR session where we reported on SOLACE. But the session, 'European perspectives of lung cancer screening: more than a decade after NLST and NELSON', aimed to evaluate its status.

There were also different lectures. One was given by Anna Kerpel-Fronius, National Korányi Institute for Pulmonology, Budapest, Hungary, on SOLACE, where she presented strategies to address the underrepresented population, women, hard-to-reach individuals, and individuals at higher risk of developing lung cancer because of additional risk factors.

Another was a lecture given by Harry De Koning, Erasmus MC, Rotterdam, the Netherlands (also the principal investigator of NELSON), who is currently the principal investigator of the 4-IN-THE-LUNG-RUN project. This project is also EU-funded, and the objective was to optimise eligibility and screening intervals and to provide a personalised approach to lung cancer screening.



Then Annemiek Snoeckx, University of Antwerp, Belgium, discussed the additional findings to report. It's a very controversial topic, because we needed to balance burdens and benefits. Lastly, Helmut Prosch, the Medical University of Vienna, Austria, who is the current ESTI president, presented the training programme for radiologists in lung cancer screening.

**Q3** The SOLACE study has revealed a higher-than-expected rate of positive findings among women, with a significant proportion of early-stage cancers detected. How should radiologists and healthcare systems prepare for the downstream clinical implications of expanded screening programmes?

I think it's mainly a question for the healthcare systems, because it's one thing to screen, but once we have a positive screening result, we need to have the management pathway set up. In France, for instance, we request that the delay between a positive screening result and further discussion should not exceed 2 weeks. We also need to evaluate the availability of surgeons, especially those who are able to perform minimally

invasive thoracic surgery. I don't know if there is a sufficient number of surgeons trained in minimally invasive surgery in all member states, so this is, I think, an important question. This is because it is a relatively new field and it requires resources. Robotic-assisted surgery is also expensive, and I don't know about the current status of deployment of this new technology. At least in France, I know it's not everywhere. So, based on the number of screened individuals, the eventuality of lung cancer, fortunately, will be relatively rare, but we need to offer the best possible care to these individuals.

**Q4** One major outcome of the SOLACE trial is that it has culminated in the formation of the European Lung Cancer Screening Alliance (ELCSA). What are the strategic priorities of this alliance, and how do you see it influencing clinical standards, policy development, and patient engagement across Europe?

I think our main objective is to ensure that lung cancer screening can be largely implemented and continued in the countries participating in SOLACE. The screening was possible because of the European funding, but

now it has to be taken on by the national healthcare systems. For this, we can provide updated guidelines, but we will also organise two events per year where we will invite stakeholders to keep them informed about, for instance, the latest advances in cost effectiveness analysis, the best strategies, optimised guidelines, and the status of implementation in different member states.

**Q5** You have been actively involved in integrating AI into lung cancer screening. In the context of ECR 2026's focus on 'The Art of AI in Clinical Practice', what are the key principles that should guide responsible and effective AI adoption in screening programmes for lung cancer and beyond?

So, we are using AI as a second reader. This is the main research question of my programme in France, the CASCADE study, where we use AI for detection in lung cancer screening in French women.

**Evaluating AI algorithms at different steps in their evolution will be important**

There, we will compare the performance of general radiologists who are assisted by AI to the performance of a double reading by chest experts who are not assisted by AI. Based on interim analysis, it's very positive, meaning that AI can help general radiologists to reach the performance of thoracic experts, which is very good because we don't have enough experts for large population screening.

Then what we are planning to do within SOLACE Plus, if it gets funding, is to benchmark different AI solutions. We need to define a minimal level of performance and an optimal level of performance. Based on this evaluation, I think it will be possible to build an economical model for reimbursement of AI solutions, to have cautious and ethical use of AI. We need to be sure about the performance, evaluating it at different levels of development of AI. I have seen that more recent versions have improved their performance, especially in the detection of subsolid nodules (those with low attenuation that are more difficult to depict) compared to solid nodules. So again, evaluating AI algorithms at different steps in their evolution will be important.

**Q6** **Where do you see the greatest opportunities for advancement in thoracic imaging and lung cancer prevention over the next 5–10 years, and how is ECR 2026 highlighting these developments?**

Firstly, ECR 2026, with its focus on AI, has shown that the use of AI is already there and that it contributes to our efficiency. The objective is to go beyond; for example, to evaluate AI in its capacity of predicting the Agatston score, for the prediction

of coronary artery disease, or other assessments of body composition anomalies, for the prediction of osteoporosis, because there's a way to correct the condition by avoiding the occurrence of vertebral fractures, if they are detected early. We could also detect other anomalies of body composition, like sarcopenia and an increase in fat content, and provide a report, helping us to provide preventive or curative measures for these anomalies. For the time being, these AI tools have not been prospectively validated. So, this is what we need to do next.

**Q7** **As France prepares for a national lung cancer screening programme, supported by initiatives such as the IMPULSION trial, what further milestones or systemic changes would you hope to see achieved across Europe before ECR 2027?**

The first thing is, I would like IMPULSION to start and to be successful in recruiting participants. We are waiting for the last legal authorisation from the National Commission of Informatics and Liberty (CNIL). But we are very well prepared to launch this programme in five regions, before extending to the rest of the regions in France.

I would also like this deployment of lung cancer screening to be the occasion where we are efficient in the denormalisation of tobacco consumption and the fight against the tobacco industry, which is trying to stay alive by developing other products that lead to nicotine addiction. We are now at the peak of the lung cancer epidemic because of the increased prevalence of smoking in women. It's the late consequence of the start of female tobacco consumption in Europe: women

who started to smoke around the 1970s and 80s, which is later than those in the USA.

Now, we are facing the consequences. In the vast majority of the member states, lung cancer is the leading cause of cancer death among women, above breast cancer, which is five times more prevalent. I think that lung cancer screening will be the time to realise just how deleterious smoking is, without blaming smokers; smokers are victims, they are not guilty. It's also the time to be more efficient in smoking cessation strategies and support smokers to help them quit.



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