Response

To the Editor:

We would like to thank Dr Reich for his comments. Dr Reich correctly points out the need to consider the balance between the benefit and harms of lung cancer screening. Our interpretation of the evidence supports a favorable balance in the high-risk cohort in which we recommend screening. We recognize that this balance is dependent on the implementation of high-quality screening programs. Dr Reich raises questions about our interpretation of benefit and harm.

Evidence of Benefit

Dr Reich cautions that the use of chest radiography in the control arm of the National Lung Screening Trial (NLST) may have led to different results than if compared with no screening. The inclusion of chest radiography as the control arm intervention was not based on the results of the Prostate, Lung, Colorectal, and Ovarian trial. It was based on knowledge that the trial was ongoing and that its results could have influenced the interpretation of the NLST if a no-screening control arm was used. Overall, we feel the results of the Prostate, Lung, Colorectal, and Ovarian trial and prior controlled trials of chest radiography screening support equivalence with no screening.

Dr Reich also highlights the lack of benefit from other trials of low-dose CT (LDCT) screening. We address this in our guideline, which reflects on differences in entry criteria (lower risk in the European trials) and study design (screening intervals and follow-up duration), while noting that these trials were not powered to demonstrate mortality reduction. The lack of reproduction of the NLST results contributed to grading our recommendation as a weak recommendation based on moderate quality evidence.

Evidence of Harm

We also agree that, for LDCT screening to succeed, it is imperative that harms are minimized. Dr Reich highlights the potential for overdiagnosis. We reference the highest quality evidence available detailing the potential magnitude of overdiagnosis in the guidelines. We also stress the importance of minimizing overdiagnosis by cautious evaluation of subsolid nodules and by the careful selection of individuals without severe comorbidities.

Dr Reich appropriately stresses the potential impact of surgical resection on disability and life expectancy of those who are overtreated. His report of the impact of lobectomy included resections performed from 1978 to 1994, with survival compared with the “healthiest smokers.” We believe that surgical methods have improved over time, resection for diagnosis can often be sublobar, and the healthiest smokers may not be the most appropriate comparator group. Regardless, the impact of resection on long-term outcomes is an important consideration.

Overall, we are comfortable that we have thoughtfully reviewed the evidence and carefully worded our recommendations, statements, and remarks to reflect the current understanding of benefit and harms from LDCT lung cancer screening.

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Activity and Outcomes From a Dedicated Pleural On-Call Service

To the Editor:

Pleural disease is increasing in frequency and is associated with more specialist evidence-based treatments. Over the last 5 years, the Oxford Pleural Unit has operated a pleural on-call service by instituting the provision of a pleural phone and e-mail service as a central point of contact for pleural-related questions, internally for the hospital trust, and externally for local general practitioners and district nurses. The phone is held during working hours, and the e-mail service is monitored daily by a member of the pleural team (consultants or pleural fellows).

To assess the activity, impact, and outcomes from the on-call service, received phone calls logged onto a datasheet were analyzed. This represents an underestimation because some cases were directly recorded onto the patient electronic record and were not analyzable for this study. All documented datasheet pleural phone referrals and e-mail referrals (March 2016-February 2017) were analyzed retrospectively. The number of cases discussed via e-mail is not a reflection of the number of e-mails because each case may have involved several e-mails over a number of days.

Outcomes avoided were defined as clearly documented changes in the referral team’s management plan, as a result of referral, which led to avoidance of unnecessary outcomes.

There were 506 cases discussed (e-mail: n = 257, phone: n = 249), with a mean of 1.9 referrals per working day. The reasons for, and outcomes of, referrals are shown in Tables 1 and 2, respectively. Outcomes such as unnecessary hospitalization or impact on length of stay were not measurable in this analysis.

The benefits of a dedicated specialized pleural service are well recognized and improve safety and reduce hospital length of stay.1,3 Patients with pleural disease are frequently cared for by different specialties, such as general medicine and oncology, without specific expertise in pleural disease. A pleural on-call service revolutionizes and facilitates the pleural service delivery, facilitates access to the service, and simplifies the referral and triaging pathways.

Research-active institutions are associated with the delivery of better care for patients.4 In addition to facilitating the delivery of appropriate pleural disease management, the pleural on-call service facilitates

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Reasons and Numbers of Referrals to the Pleural On-Call Service (N = 506)</th>
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<tbody>
<tr>
<td>Reason for Referral</td>
<td>Percentage of Total Referrals (No.)</td>
</tr>
<tr>
<td>Pleural effusion (new or known)</td>
<td>66.8 (338)</td>
</tr>
<tr>
<td>Empyema (diagnosed or suspected)</td>
<td>8.3 (42)</td>
</tr>
<tr>
<td>Pneumothorax</td>
<td>6.5 (33)</td>
</tr>
<tr>
<td>Indwelling pleural catheter-related queries</td>
<td>5.1 (26)</td>
</tr>
<tr>
<td>Other (eg, pleurodesis-related)</td>
<td>13.2 (67)</td>
</tr>
</tbody>
</table>

References


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