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Comment on: "Low-dose computed tomography screening for lung cancer in people with workplace exposure to asbestos"

To the Editor,

We read the recent article by Maisonneuve et al. entitled 'Low-dose computed tomography screening for lung cancer in people with workplace exposure to asbestos' [1]. As proposed in the correspondence by Harris et al. [2], we also advise that further work is required before guidelines are written excluding never or light smokers from lung cancer screening programs for asbestos-exposed workers. Neither Maisonneuve et al nor Harris et al. mention the findings of our recent article that support low-dose computed tomography (LDCT) screening for lung cancer in a high-risk population of asbestos-exposed subjects [3]. In our publication, we reported on the 10-year mortality of a cohort of 2433 asbestos-exposed men enrolled in Monfalcone northeastern Italy. In brief, we showed a marked 59% reduction of lung cancer mortality in the ATOM002 cohort [4] enrolled in the LDCT screening compared with ordinary surveillance based on clinical visits and chest x-rays. When these results were stratified by smoking, the mortality reduction among LDCT screened subjects was 52% in never smokers, 71% in former smokers and 37% in current smokers. Although based on sparse data, these estimates support the conclusion of an overall efficacy of the LDCT screening for lung cancer in workers highly exposed to asbestos, independently from smoking status. Moreover, despite the fact that LDCT screening did not reduce the mortality for mesothelioma, in our study the mortality for all causes, was decreased among screened subjects by 39%. The corresponding distribution by smoking in mortality reduction was the following: 51% among never, 13% among former and 33% among current smokers.

Correctly, Maisonneuve et al [1] estimated in the review component of their article that at baseline screening our ATOM002 cohort showed a lung cancer detection of 0.28% in never smoker and 1.16% in ever smokers. Indeed, these differences, should be considered in cost-effectiveness analyses. However, because of the mounting evidence that LDCT lung cancer screening among occupationally asbestos-exposed subjects is safe and effective and that these subjects do not have other effective instruments to reduce their risk to die from lung cancer and possibly other causes, we propose that in an ethical decision-making process saving lives remains the prime objective of public health as compared to other considerations.

Declaration of Competing Interest

None.

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