

for additional studies. Nonetheless, the specific hypothesis that combining chlorhexidine with enhanced dental cleaning will be more effective than rinsing or swabbing with chlorhexidine alone has already been evaluated in at least 3 randomized clinical trials.¹⁻³ These trials compared oral care with chlorhexidine alone vs oral care with chlorhexidine combined with mechanical toothbrushing 3 times per day. None of the 3 trials found any differences in VAP rates between study arms. In addition, 3 of the high-quality, double-blinded studies included in our meta-analysis did include toothbrushing in both the intervention and control arms.⁴⁻⁶ On meta-analysis restricted to these 3 studies, there was still no apparent effect of chlorhexidine on VAP (RR, 0.99; 95% CI, 0.61-1.60) or mortality (RR, 1.14; 95% CI, 0.69-1.88).

We wish to reiterate that our study should not be construed as a recommendation against oral care for ventilated patients. On the contrary, we continue to believe that there are compelling reasons to provide rigorous oral care for ventilated patients independent of the issue of VAP prevention. These include maintaining oral hygiene and enhancing patient comfort. Our analysis simply suggests that adding chlorhexidine to an oral care regimen does not confer additional benefit and may in fact introduce some risk.

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1. Pobo A, Lisboa T, Rodriguez A, et al; RASPALL Study Investigators. A randomized trial of dental brushing for preventing ventilator-associated pneumonia. *Chest*. 2009;136(2):433-439.
2. Munro CL, Grap MJ, Jones DJ, McClish DK, Sessler CN. Chlorhexidine, toothbrushing, and preventing ventilator-associated pneumonia in critically ill adults. *Am J Crit Care*. 2009;18(5):428-437.
3. Lorente L, Lecuona M, Jiménez A, et al. Ventilator-associated pneumonia with or without toothbrushing: a randomized controlled trial. *Eur J Clin Microbiol Infect Dis*. 2012;31(10):2621-2629.
4. Bellissimo-Rodrigues F, Bellissimo-Rodrigues WT, Viana JM, et al. Effectiveness of oral rinse with chlorhexidine in preventing nosocomial respiratory tract infections among intensive care unit patients. *Infect Control Hosp Epidemiol*. 2009;30(10):952-958.
5. Scannapieco FA, Yu J, Raghavendran K, et al. A randomized trial of chlorhexidine gluconate on oral bacterial pathogens in mechanically ventilated patients. *Crit Care*. 2009;13(4):R117.
6. Meinberg MC, Cheade MD, Miranda AL, Fachini MM, Lobo SM. The use of 2% chlorhexidine gel and toothbrushing for oral hygiene of patients receiving mechanical ventilation: effects on ventilator-associated pneumonia. *Rev Bras Ter Intensiva*. 2012;24(4):369-374.

Current Practices for Lung Cancer Screening: Too Slow or Too Fast?

Boiselle and colleagues¹ provide an alarming evaluation of current practices for lung cancer screening at leading academic medical centers.

First, there is no evidence that anyone is concerned about the implementation of a quality assurance program, which should be a prerequisite. Second, National Lung Screening Trial participants were better educated than the general US population, and the median cigarette exposure was 48 pack-years, far from the current practice criteria of "at least 20 pack-years."² These factors constitute a very slippery slope.

Lastly, there is no evidence that truly informed consent was obtained. I am not aware of any information leaflets giving figures with a range for the expected benefit (number needed to screen for a period to save 1 life) and harm due to false-positive results and overdiagnosis. At least, this is not the case for the 4-page long information leaflet from the US Preventive Services Task Force, which recommends screening.³ Is this information?

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1. Boiselle PM, White CS, Ravenel JG. Computed tomographic screening for lung cancer: current practice patterns at leading academic medical centers. *JAMA Intern Med*. 2014;174(2):286-287.
2. Aberle DR, Adams AM, Berg CD, et al; National Lung Screening Trial Research Team. Baseline characteristics of participants in the randomized national lung screening trial. *J Natl Cancer Inst*. 2010;102(23):1771-1779.
3. US Preventive Services Task Force. Understanding Task Force recommendations: screening for lung cancer. December 2013. <http://www.uspreventiveservicestaskforce.org/uspstf13/lungcan/lungcanfact.pdf>. Accessed February 10, 2014.

In Reply We thank Dr Braillon for his interesting comments regarding our recent Research Letter. With regard to the perception of a lack of concern for the implementation of a quality assurance program, we fully agree that this is an area of paramount importance for computed tomographic screening for lung cancer. Indeed, we emphasized in our publication that the variability in screening practices that we observed suggested the need for formalized radiology guidelines with a focus on the technical and logistical aspects of screening.¹

Fortunately, since the time of our publication, the American College of Radiology has recently developed several resources to address key quality assurance issues, including a set of computed tomographic screening practice parameters,² a Lung Imaging Reporting and Data System (Lung-RADS), and a process for site accreditation.³ Open-access, patient-centered, educational materials have also been developed, including a set of detailed guidelines from the National Comprehensive Cancer Network.⁴ Such materials have the potential to facilitate shared decision making and informed consent, which are critical components of a screening program.

Collectively, these resources will help to ensure that patients in the United States have access to uniform, quality care and a similar life-saving benefit from these examinations, as demonstrated in the National Lung Screening Trial.^{5,6}

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1. Boiselle PM, White CS, Ravenel JG. Computed tomographic screening for lung cancer: current practice patterns at leading academic medical centers. *JAMA Intern Med.* 2014;174(2):286-287.
2. Kazerooni EA, Austin JHM, Black WC, et al. ACR-STR practice parameter for the performance and reporting of lung cancer screening thoracic computed tomography (CT): 2014 (Resolution 4). *J Thorac Imaging.* 2014;29(5):310-316.
3. American College of Radiology. Lung cancer screening resources. <http://www.acr.org/Quality-Safety/Resources/Lung-Imaging-Resources>. Accessed August 20, 2014.
4. National Comprehensive Cancer Network. NCCN Guidelines for Patients: version 1. 2014. http://www.nccn.org/patients/guidelines/lung_screening/index.html#2/z. Accessed August 20, 2014.
5. Boiselle PM. CT screening for lung cancer: filling in the gaps. *J Thorac Imaging.* 2013;28(6):329-330.
6. Aberle DR, Adams AM, Berg CD, et al; National Lung Screening Trial Research Team. Reduced lung-cancer mortality with low-dose computed tomographic screening. *N Engl J Med.* 2011;365(5):395-409.