

Bronchioalveolar Lung Cancer: Screening and Overdiagnosis

TO THE EDITOR: Johnson et al¹ provides us a comprehensive state of the art for lung cancer, from pathology to screening. They stated that screening seems warranted for individuals who meet the National Lung Cancer Screening Trial (NLCST) criteria for lung cancer risk.¹ They rightly stressed the caveats of screening: high rate of false-positive results, false-negative results, the potential for unnecessary follow-up testing, radiation exposure, overdiagnosis, anxiety, depression, and changes in quality of life, as well as substantial financial costs conclusion.¹

Can they provide us with perspectives for limiting these harms as in the pathology section, they pointed out the modifications of the WHO classification system with the discontinuation of the term “bronchioloalveolar carcinoma” (BAC)?¹

First, in the NLCST, 79% BAC detected are overdiagnoses.² This is not trivial, as there are 110 cases of BAC (10.5% of lung cancers diagnosed) in the computed tomography group (CT) versus 35 (3.8%) in the radiography group.

Second, NLCST was published in 2011 but coded histologic features according to the WHO 2000 International Classification of Diseases for Oncology. The trial was neither updated for the 2004

revision, nor for the more recent pathologic classification of BAC which now exists.³

Last, there was no published evaluation of the reliability of the histologic assessment, in contrast to CT findings.

Is a reanalysis of the histologic assessment of the NLCST warranted? This can be important as the new classification of BAC seems to be associated with characteristic CT findings.⁴

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AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author(s) indicated no potential conflicts of interest.

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