Our goal was to present an objective review of both the benefit and the potential harm of screening. The evidence base for mortality benefit in screening studies to date, supported by modeling studies, is described. Similarly, the evidence base for potential harms, including the consequences of false-positive findings, radiation exposure, psychological distress, and overdiagnosis, is also described. An understanding of the balance between benefit and potential harm is critical to the discussion that should occur between providers and patients when lung cancer screening is considered, and health policy in the United States now mandates this discussion (2). Whether outcomes of the National Lung Screening Trial (NLST) relating to evaluation of screen-detected nodules, including the number of invasive procedures and surgeries, will be reproduced once screening is generalized to the broader community will be known only if those outcomes are monitored prospectively. Successful implementation of screening registries, as recommended by the Centers for Medicare & Medicaid Services, may ensure such outcomes are objectively measured.

We agree with the comment that follow-up of positive screening findings with low-dose computed tomography scans will reduce the cumulative radiation dose, and that advances in imaging technology will minimize radiation exposure, as was stated in the review. With regard to screening individuals who do not meet the criteria of NLST, we agree that some individuals will have objectively quantifiable lung cancer risks that exceed the average risk of the NLST study population (3–5). Lung cancer risk varies even within the NLST study population, with the important observation that most of the mortality benefit was achieved in those subgroups with quantifiable highest risk, whereas the entire study population, including those at lower risk, was subject to potential harm (6). Although Drs. Zulueta and de-Torres argue that "there is no evidence that screening individuals with different criteria [than those tested in a randomized controlled trial] would not be effective," we would caution that there is no evidence that screening individuals with different criteria is effective. In such cases, the benefit is unknown but potential harm exists; in fairness to the patient, a balanced discussion acknowledging both should occur. ■

Author disclosures are available with the text of this letter at www.atsjournals.org.

Lynn T. Tanoue, M.D.
Yale School of Medicine
New Haven, Connecticut

Nichole T. Tanner, M.D.
Medical University of South Carolina
Charleston, South Carolina

Michael K. Gould, M.D.
Kaiser Permanente Research
La Cañada Flintridge, California

Gerard A. Silvestri, M.D.
Medical University of South Carolina
Charleston, South Carolina

References

1. Tanoue LT, Tanner NT, Gould MK, Silvestri GA. Lung cancer screening. *Am J Respir Crit Care Med* 2015;191:19–33.
2. Decision Memo for Screening for Lung Cancer with Low Dose Computed Tomography (LDCT) (CAG-00439N). Centers for Medicare & Medicaid Services; 2015 Feb 5 [accessed 2015 Feb 6]. Available from: http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274
3. Tammemägi MC, Katki HA, Hocking WG, Church TR, Caporaso N, Kvale PA, Chaturvedi AK, Silvestri GA, Riley TL, Commins J, *et al*. Selection criteria for lung-cancer screening. *N Engl J Med* 2013;368:728–736.
4. Bach PB, Kattan MW, Thornquist MD, Kris MG, Tate RC, Barnett MJ, Hsieh LJ, Begg CB. Variations in lung cancer risk among smokers. *J Natl Cancer Inst* 2003;95:470–478.
5. Cassidy A, Myles JP, van Tongeren M, Page RD, Liloglou T, Duffy SW, Field JK. The LLP risk model: an individual risk prediction model for lung cancer. *Br J Cancer* 2008;98:270–276.
6. Kovalchik SA, Tammemagi M, Berg CD, Caporaso NE, Riley TL, Korch M, Silvestri GA, Chaturvedi AK, Katki HA. Targeting of low-dose CT screening according to the risk of lung-cancer death. *N Engl J Med* 2013;369:245–254.

Erratum: Bioactive Lipids in Emphysema: Decoding Fat to Reveal COPD Phenotypes

An editorial by Drs. Mehdi Mirzaie and Farrah Kheradmand published in the February 1, 2015, issue of the *Journal* (1) contains errors in the author affiliation section. Dr. Mirzaie's correct affiliations are: [1]Department of Computational Biology, Faculty of High Technologies, Tarbiat Modares University, Tehran, Iran; and [2]School of Biological Sciences, Institute for Research in Fundamental Sciences (IPM), Tehran, Iran. ■

Reference

1. Mirzaie M, Kheradmand F. Bioactive lipids in emphysema: decoding fat to reveal COPD phenotypes [editorial]. *Am J Respir Crit Care Med* 2015;191:241–243.

Erratum: Daily Rifapentine for Treatment of Pulmonary Tuberculosis: A Randomized, Dose-Ranging Trial

There is an error in the article by Dorman and colleagues (1), which appeared in the February 1, 2015, issue of the *Journal*. The authors omitted the following statement from the Acknowledgment section of the article:

> The authors thank Dr. Charles Peloquin and the staff of the Infectious Disease Pharmacokinetics Laboratory at the University of Florida for providing rifapentine plasma concentration data used in the analyses. ■

Reference

1. Dorman SE, Savic RM, Goldberg S, Stout JE, Schluger N, Muzanyi G, Johnson JL, Nahid P, Hecker EJ, Heilig CM, *et al*.; Tuberculosis Trials Consortium. Daily rifapentine for treatment of pulmonary tuberculosis: a randomized, dose-ranging trial. *Am J Respir Crit Care Med* 2015;191:333–343.