

COMARE 12th REPORT:

The impact of personally initiated X-ray computed tomography scanning for the health assessment of asymptomatic individuals.

Comments from the British Institute of Radiology

The Institute welcomes the opportunity to comment on this report. We congratulate the Committee on its report and are in general agreement with all its recommendations. We have a few detailed comments that are given below.

General

While the main document talks about screening, the Recommendations do not mention this. Perhaps they should.

The document suggests that whole body CT scanning is not performed in the UK. It is certainly done as an adjunct to PET-CT scans.

Perhaps there should be a generalised exception for scans performed as part of an approved and ethically justified clinical trial – where patient entrance criteria are clearly defined. Perhaps this was discussed by the group and a decision was made to avoid mention of this possibility so as not to provide any route around the Recommendations for self-referral centres.

Specifics

Recommendation 2

Statements such as the one saying that false positives and false negative rates must be quoted make good sense but are often much more complicated than they appear. For example, the risk of a false positive in finding an incidental lung nodule will be dependent upon where the patient has lived in the past - benign lung nodules being much more commonly found in the cotton growing belt of the USA due to their particular pattern of infectious disease exposure.

Recommendation 5

This steps around the point of the more sophisticated dose modulation abilities of the latest generation of scanners. Was this intentional? One might argue that such scanners are able to optimise dose as they scan. Such technical optimisation does not satisfy (in our opinion) the full intentions of IR(ME)R 2000. Additional words may be necessary to clarify this.

Presumably centres could eventually be offering scanning as part of nationally agreed screening programmes – so perhaps this wording should be carefully considered.

Recommendation 6

It is recommended that CT scanning for spinal conditions, osteoporosis and body fat assessment should cease. However, there may be circumstances in which these investigations are justified as part of carefully controlled and ethically approved clinical trials

Recommendation 7

It is important for government policies and statements to be fully consistent. NIHR have recently put out a call for proposals on protocol development for CT lung cancer screening.

Also in other countries, treatment techniques are developing rapidly. One example would be the development in Japan of carbon ion radiotherapy and the use of a single fraction of Carbon ions to treat small, early stage lung tumours. This is a developing treatment which is an alternative to surgery which may become quite widely available in Europe (though not in UK) in the next 5 years. We must be careful that these recommendations will stand the test of time.

Section 7.23

This states: *In HIV/AIDS patients, skinfold measurements of central subcutaneous fat correlated with both DEXA and abdominal CT, suggesting that the simpler, non-radiation methodology is adequate for both research and healthcare purposes (Florindo et al, 2004).*

While a population correlation may exist, in general the variability around the line of regression (i.e. the biological variability) means that skin-fold measurements are very unlikely to provide a useful clinical index for an individual patient.

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