Longkanker screening door het oog van de radioloog

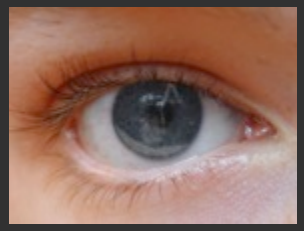
A radiologist's perspective

Annemie Snoeckx

Antwerp University Hospital

TOGA najaarssymposium
19 oktober 2012

I. Introduction



Lung cancer screening: A radiologist's perspective

I am ...

- a radiologist @ UZA
- thoraco-abdominal imaging

I am not ...

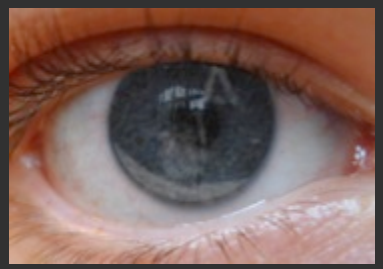
- involved in lung screening trials
- an engineer/specialist in radiation protection

Radiation dose ?

What kind of examination ?

How to detect lesions ?

LUNG CANCER SCREENING



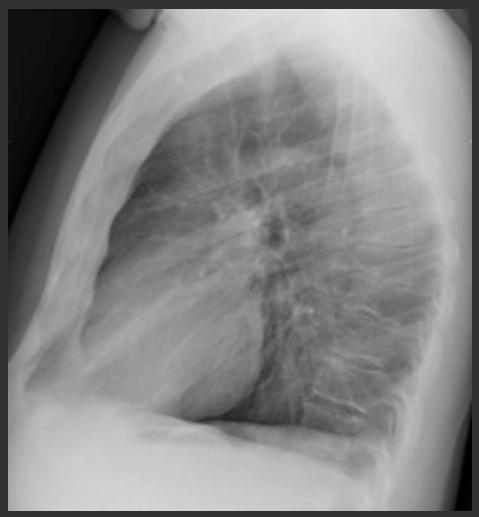
What do radiologists think ?

Lesion characterization ?

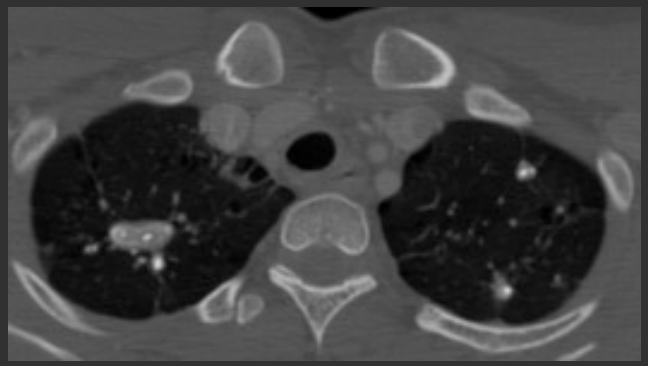
Extrathoracic findings ?

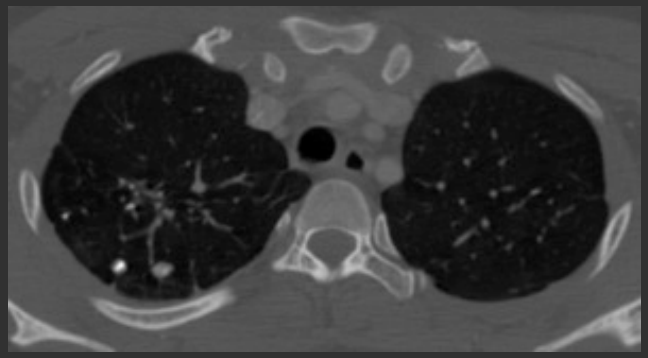
2. What kind of examination ?

Radiography



- The most commonly used technique in clinical practice
  - To rule out chest disease
  - To study the effects of treatment
  - To monitor patients with chest abnormalities
- Short examination time – low cost – easy access
- Low sensitivity and specificity
- High interreader variability

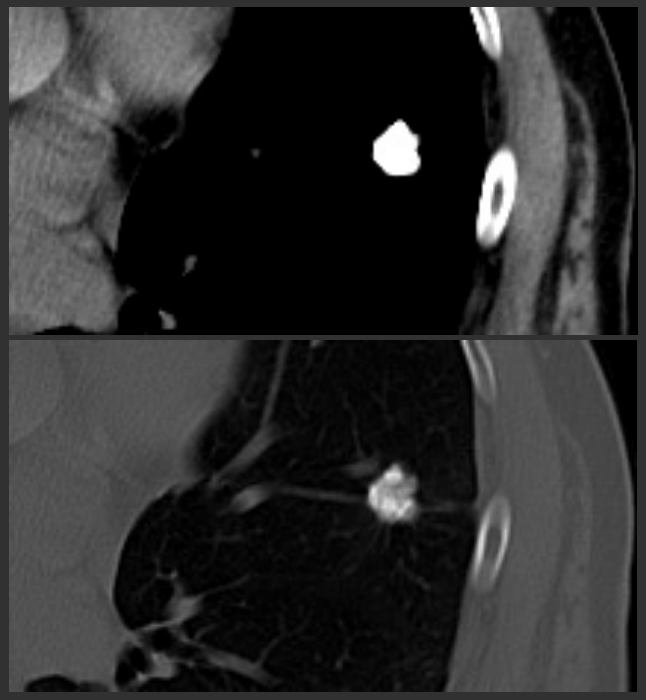




Radiography

- Often reveals nodules
- 77% of nodules smaller 7 mm visualized on a chest radiograph → calcified
- Higher probability of representing calcified granulomas
- Detection is limited by overlapping structures and low contrast of the nodule

Ketai et al. Chest 2000



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Ketai et al. Chest 2000

SCREENING

Radiograph

or

CT

Screening with chest radiography

- Purpose: to estimate the performance of digital chest radiography for detection of lung cancer
- Patients recruited from two screening sites, participating in the NELSON trial
- Conclusion:
  - High rates of lung cancer detection can be achieved at a stage when lesions are seen at CT screening
  - BUT only at the expense of a low specificity that results in an excessive number of work-up CT examinations

De Hoop et al.
Radiology 2010

Screening with chest radiography

De Hoop et al.
Radiology 2010

Quekel et al.
Eur J Radiol 2001

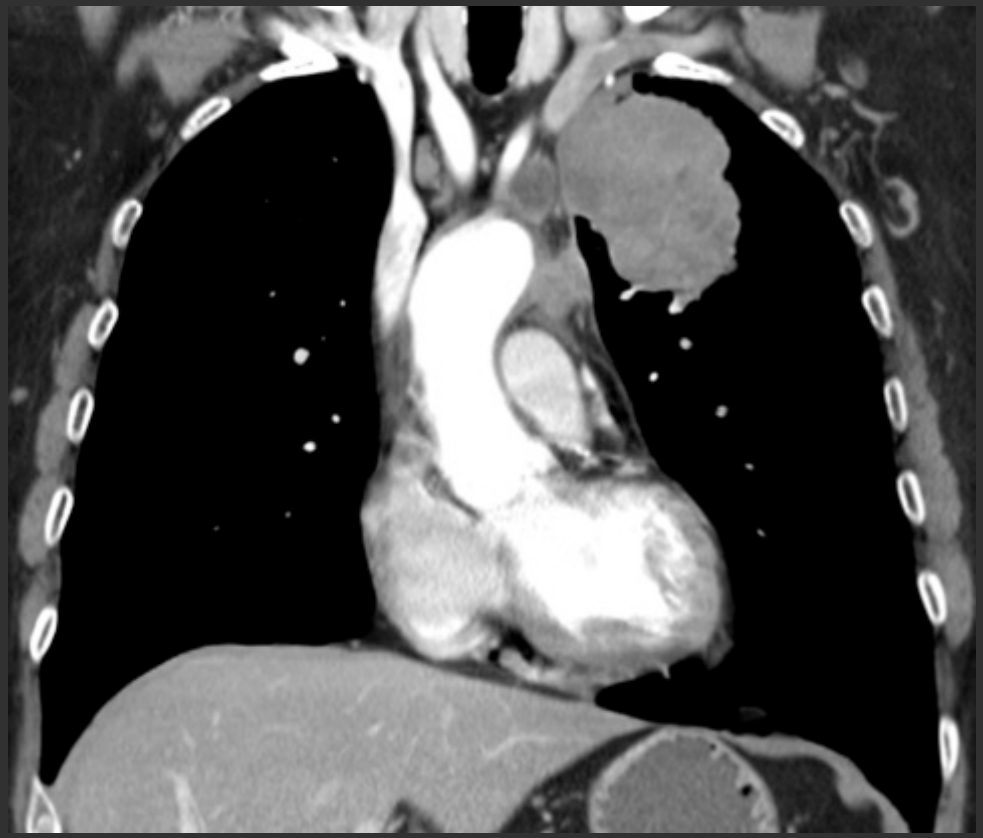
Potchen et al.
Radiology 2000

Gavelli et al.
Cancer 2000

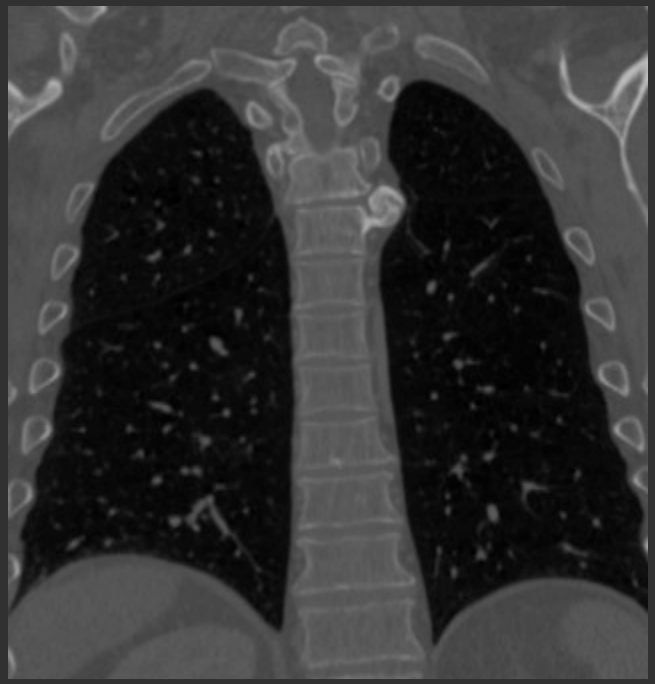
Toyoda et al.
Br J Cancer 2008

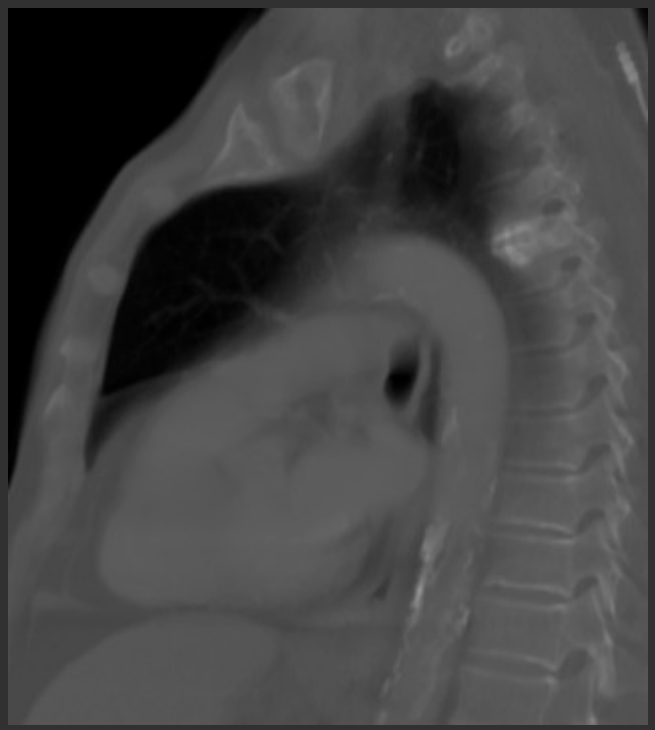
Monnier-Cholley et al.
Radiology 2004

- Sensitivity of conventional digital chest radiography → range from 36% to 84%
- Depending on the study population
- Smokers → more COPD → more difficult interpretation of chest radiographs
- Low specificity that results in an excessive numer of work-up CT examinations



VEK 6-10-37





VHJ 9-7-43

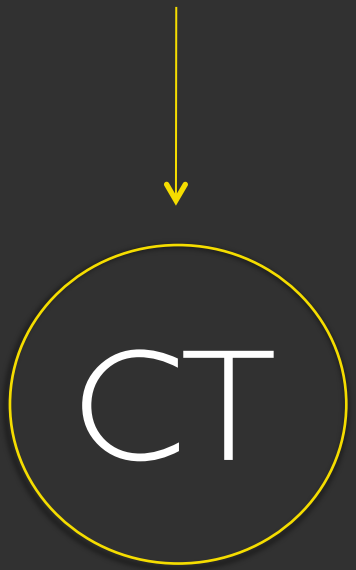
DCR – 31-12-54

Mucinous adenocarcinoma
broncho-alveolar growth pattern


L


LAT

What kind of examination ?

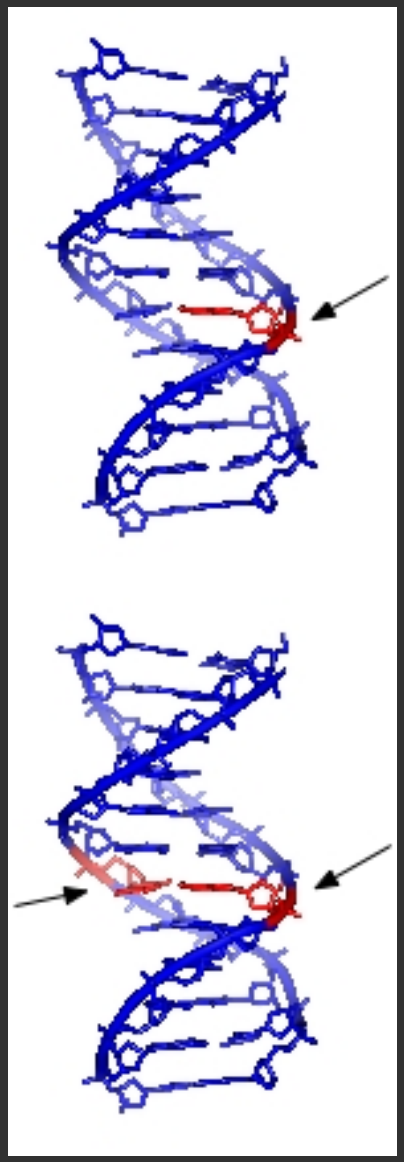


Lung cancer screening with CT

- CT affords several advantages over chest radiography
- Cross-sectional data acquisition and display → reduces the problem of overlying structures
- Contrast in the lung parenchyma is greater with CT → visualization of more subtle abnormalities

- Higher cost
- Screening population = healthy population → minimize radiation exposure for screening

3. Radiation dose



X-rays

↓

Single and
double-strand breaks

↓

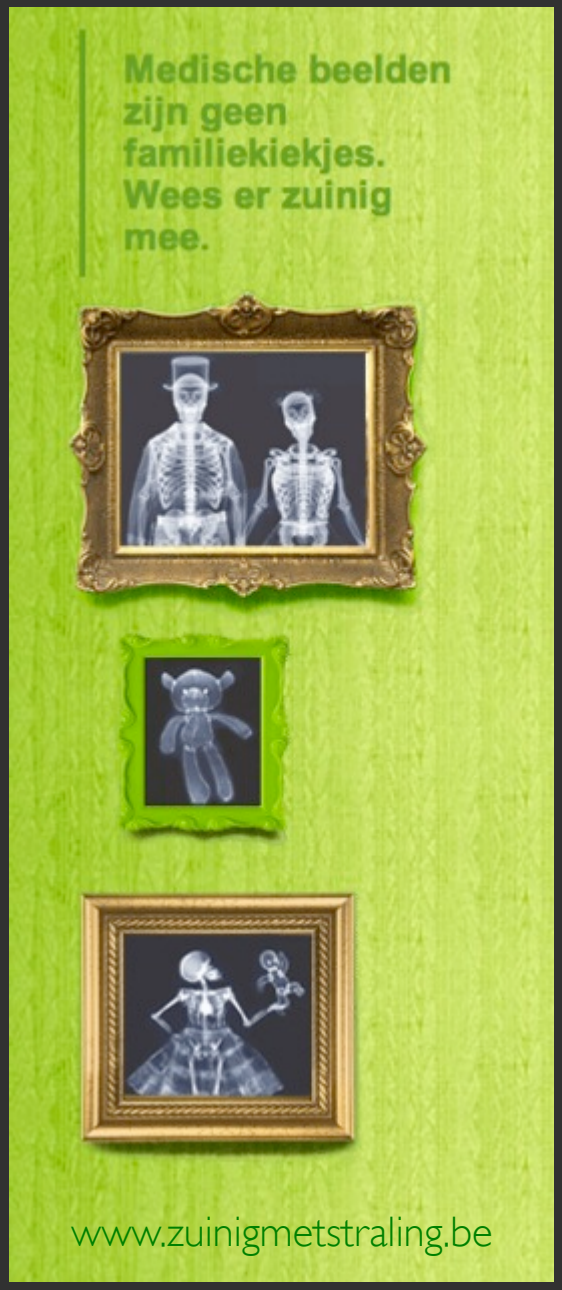
DNA Repair

↓

Chromosome aberrations,
mutations, cell death

↓

Tumorgenesis



De Standaard

NIEUWS INFOTHEEK E-KRANT ARCHIEF+ DIENSTEN IPAD/IPHONE

voor abonnees › Infotheek

Medische beelden zijn geen familiekiekjes

woensdag 01 augustus 2012, 05u00 Bron: www.gezondheid.be

gezondheid.bewww.zuinigmetstraling.be ;www.health.belgium.be/richtlijnen-medische-beeldvorming

★ AANRADEN 1

rr

'Medische beeldvorming' is een verzamelnaam voor verschillende technieken om het lichaam in beeld te brengen. Medische beeldvorming heeft een enorme vooruitgang mogelijk gemaakt in de moderne geneeskunde. Röntgenfoto's, MRI of CT-scans zijn onmisbaar om diagnoses te


WHICH BUTTON DO I PUSH?
USUALLY WE JUST PUNCH 'EM BOTH.
DETECT CANCER
CAUSE CANCER
MAMMOGRAM 5000 CONTROL PANEL
© 2006 by Truth Publishing International, Ltd.
CONCEPT-MIKE ADAMS ART-DAN BERGER
WWW.NATURALNEWS.COM

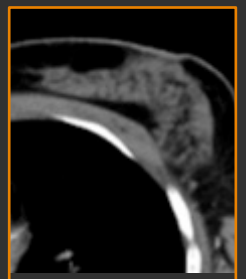
"Radiation can be used for great benefit to humanity and with minimal risk, a risk comparable to or lower than those commonly accepted as ordinary part of daily life such as driving to work"

National Institutes of Health
April 2000

Is radiation dose an issue in lung cancer screening ?

Chest CT

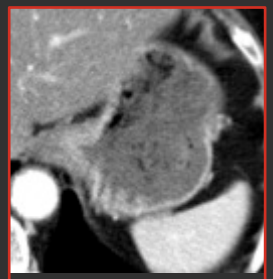
Lung parenchyma



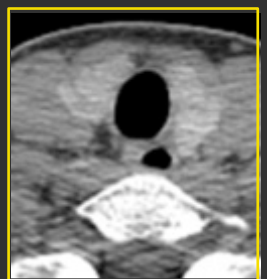
Breast

Esophagus

Liver



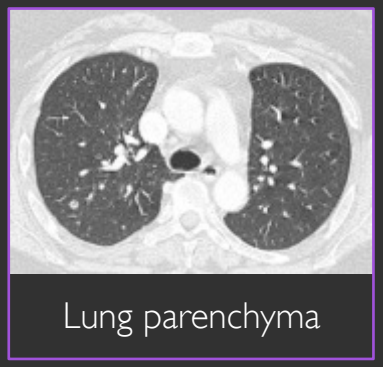
Stomach



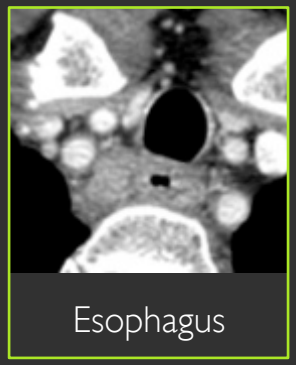
Thyroid gland

Chest CT

Radiation-associated cancer risk at age 55

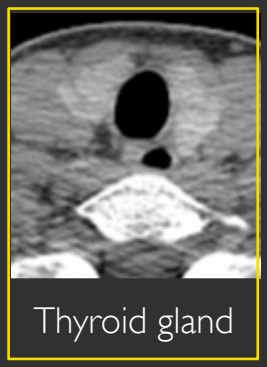

Lung parenchyma


Breast


Esophagus


Liver


Stomach


Thyroid gland

is much HIGHER

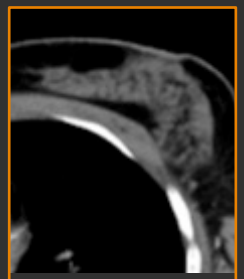
is much LOWER than at younger ages

Chest CT

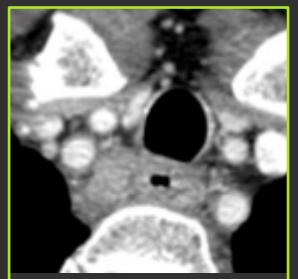
Radiation-associated cancer risk at age 55

Lung parenchyma

is much HIGHER

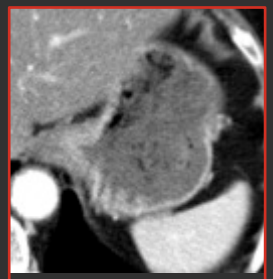


Breast

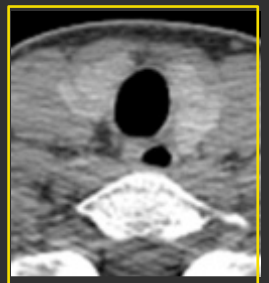


Esophagus

Liver



Stomach



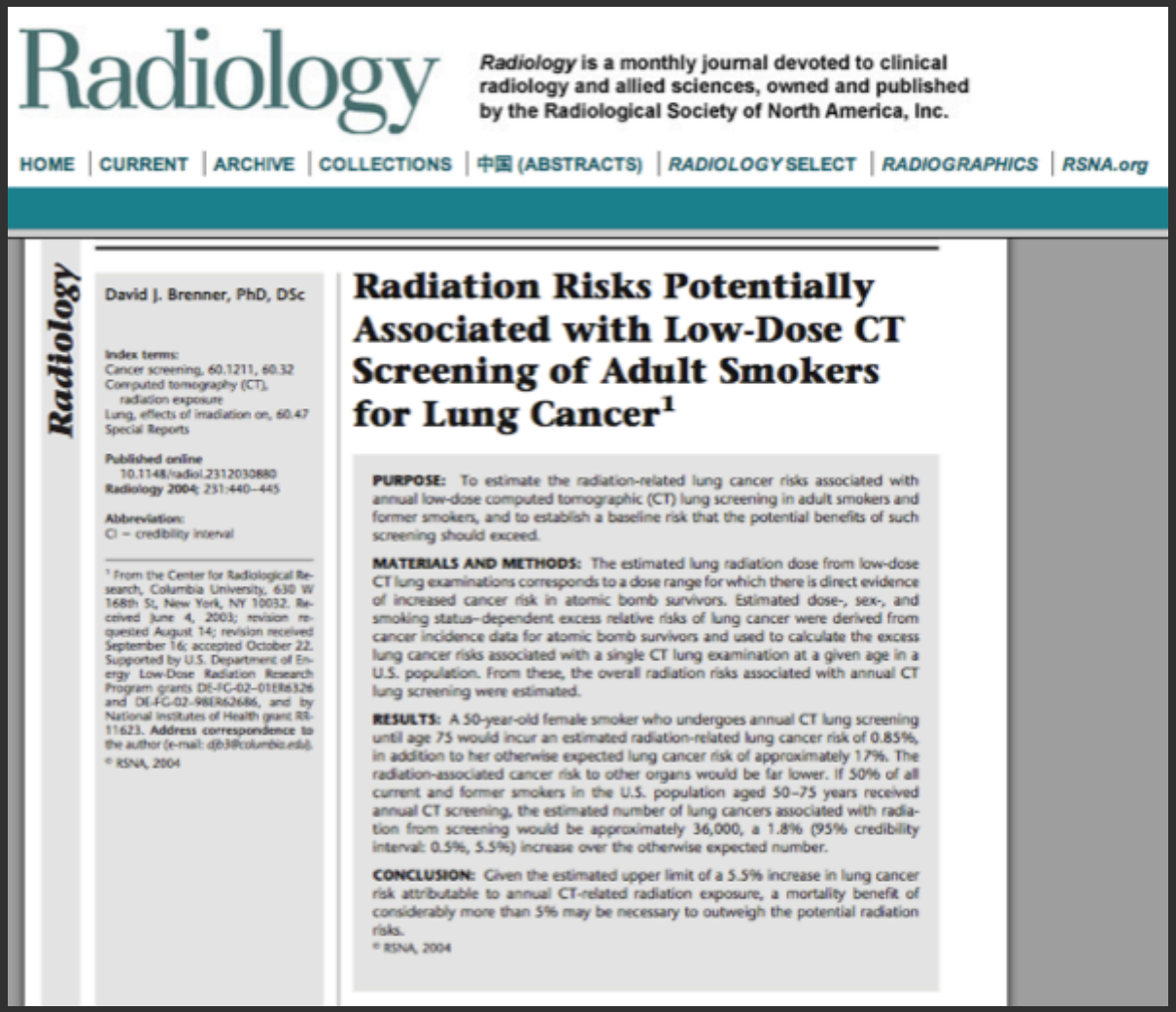
Thyroid gland

is much LOWER than at younger ages

Is radiation dose an issue in lung cancer screening ?

Yes it is

Radiation-associated lung cancer risk



Radiology

Radiology is a monthly journal devoted to clinical radiology and allied sciences, owned and published by the Radiological Society of North America, Inc.

Radiology

David J. Brenner, PhD, DSc

Index terms:
Cancer screening, 60.1211, 60.32
Computed tomography (CT), radiation exposure
Lung, effects of irradiation on, 60.47
Special Reports

Published online
10.1148/radiol.2312030880
Radiology 2004; 231:440–445

Abbreviation:
CI = credibility interval

[1] From the Center for Radiological Research, Columbia University, 630 W 168th St, New York, NY 10032. Received June 4, 2003; revision requested August 14; revision received September 16; accepted October 22. Supported by U.S. Department of Energy Low-Dose Radiation Research Program grants DE-FC-02–01ER63326 and DE-FG-02–98ER62686, and by National Institutes of Health grant RR-11623. **Address correspondence to** the author (e-mail: djb38@columbia.edu).

Radiation Risks Potentially Associated with Low-Dose CT Screening of Adult Smokers for Lung Cancer[1]

PURPOSE: To estimate the radiation-related lung cancer risks associated with annual low-dose computed tomographic (CT) lung screening in adult smokers and former smokers, and to establish a baseline risk that the potential benefits of such screening should exceed.

MATERIALS AND METHODS: The estimated lung radiation dose from low-dose CT lung examinations corresponds to a dose range for which there is direct evidence of increased cancer risk in atomic bomb survivors. Estimated dose-, sex-, and smoking status–dependent excess relative risks of lung cancer were derived from cancer incidence data for atomic bomb survivors and used to calculate the excess lung cancer risks associated with a single CT lung examination at a given age in a U.S. population. From these, the overall radiation risks associated with annual CT lung screening were estimated.

RESULTS: A 50-year-old female smoker who undergoes annual CT lung screening until age 75 would incur an estimated radiation-related lung cancer risk of 0.85%, in addition to her otherwise expected lung cancer risk of approximately 17%. The radiation-associated cancer risk to other organs would be far lower. If 50% of all current and former smokers in the U.S. population aged 50–75 years received annual CT screening, the estimated number of lung cancers associated with radiation from screening would be approximately 36,000, a 1.8% (95% credibility interval: 0.5%, 5.5%) increase over the otherwise expected number.

CONCLUSION: Given the estimated upper limit of a 5.5% increase in lung cancer risk attributable to annual CT-related radiation exposure, a mortality benefit of considerably more than 5% may be necessary to outweigh the potential radiation risks.

Radiation-associated lung cancer risk

1. Risk is highest in those aged 55 years at exposure
2. Evidence that radiation damage and smoking damage interact synergistically
    - Hard to quantify
    - Interaction is near multiplicative
    - Estimated risks are higher for current smokers than for former smokers
    - Higher for heavy ever-smokers compared with light ever-smokers

David Brenner,
Radiology 2004

Radiation-associated lung cancer risk

- Radiation risks = difficult calculations → data based on Japanese atomic bomb survivors
- Yearly screening, from age 50 (to 75) in a female smoker

  → 5% increase in risk
- Yearly screening, from age 50, in a male smoker

  → 1,5% increase in risk

! *A mortality benefit of considerably more than 5% may be necessary to outweigh the potential radiation risks*

David Brenner, Radiology 2004

Is radiation dose an issue in lung cancer screening ?

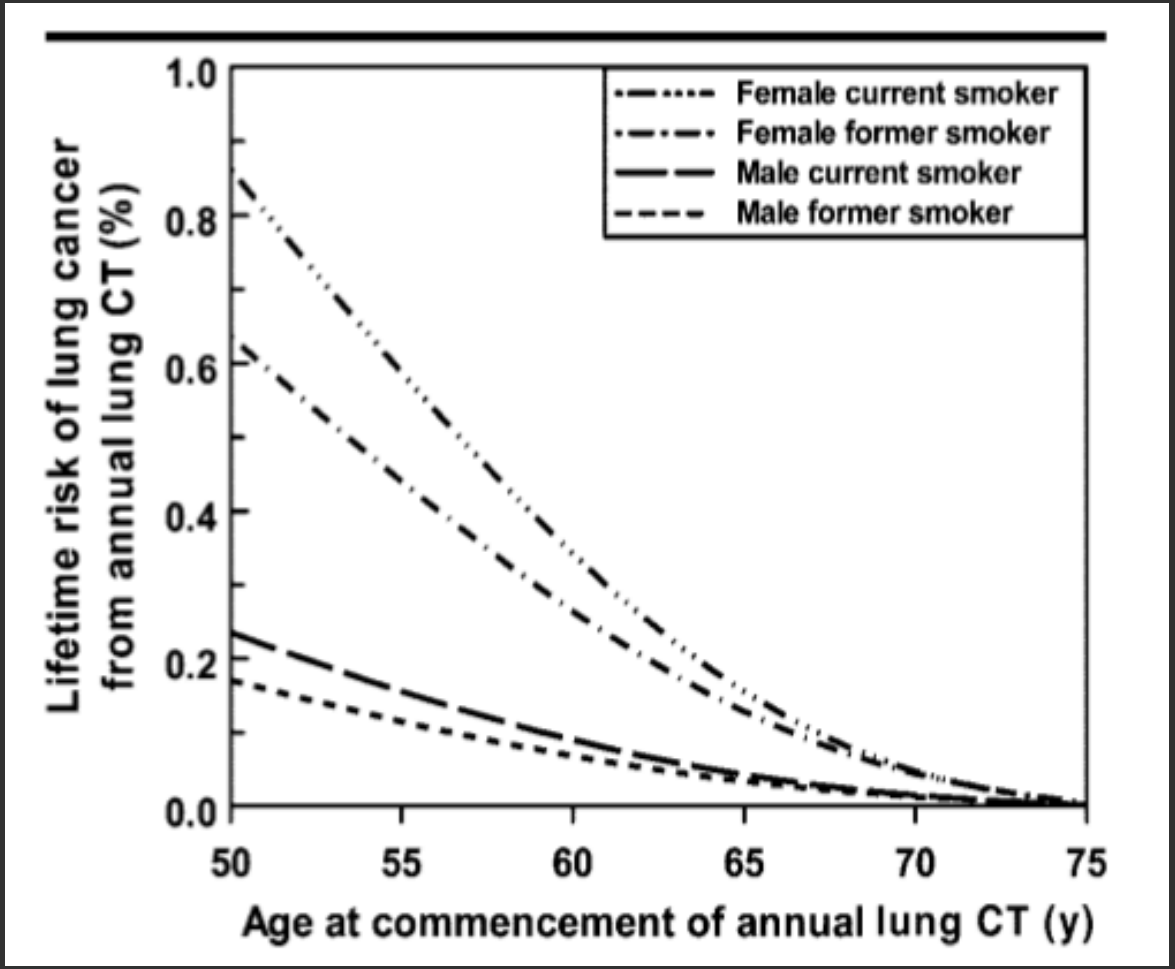
Yes It Is !

Can we reduce this risk ?

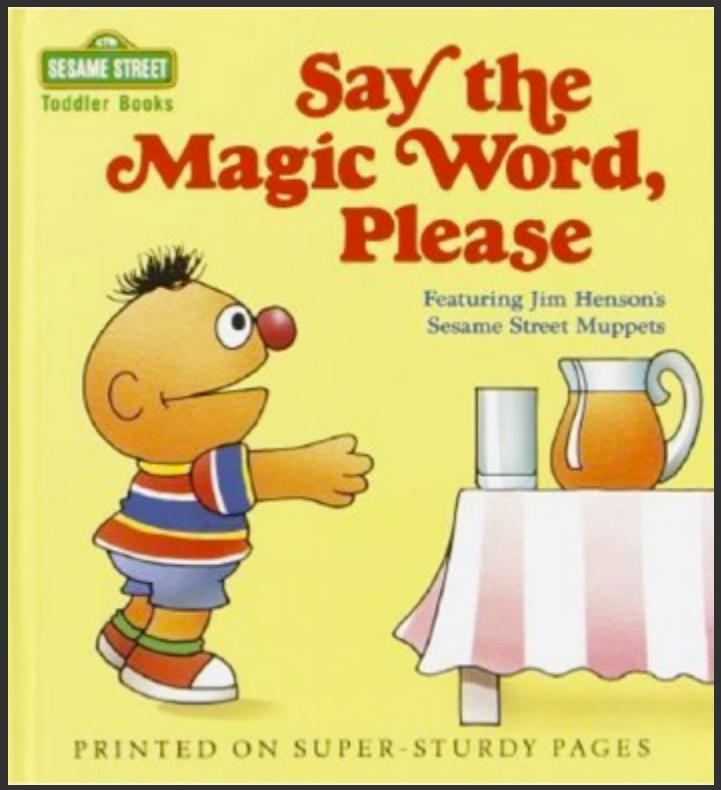
Yes We Can !

Age

"It is clear that radiation-related risks decrease rapidly with increasing age at commencement of screening"



Dose



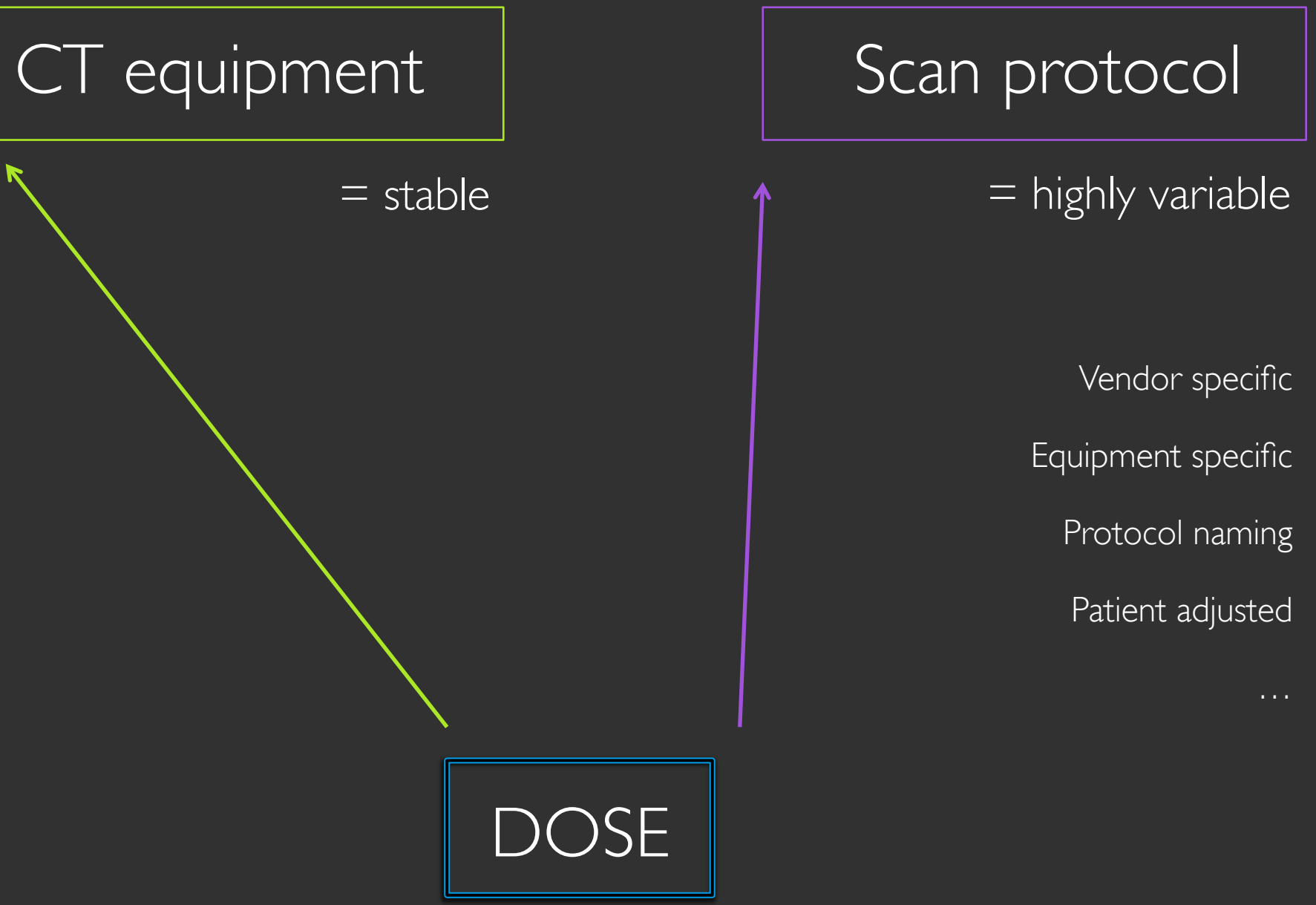
LOW DOSE

Definition of "low-dose CT"

"Lower than standard dose"

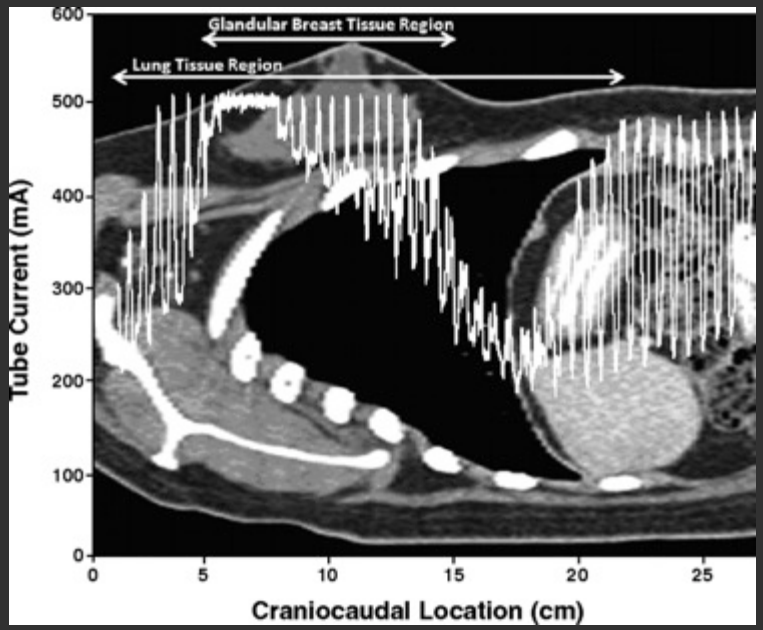
Definition of "standard dose"

! No definition
No standardization


CT equipment
= stable
Scan protocol
= highly variable
Vendor specific
Equipment specific
Protocol naming
Patient adjusted
…
DOSE

What are we doing ?
What can we do ?

- Tube current modulation
  - Adaptive dose technology that automatically adjusts tube output (mA) to compensate for changes in patient thickness



Tamm EP, Rong XJ et al.
Radiographics 2011

McCollough C, Bruesewitz MR et al.
Radiographics 2006

Angel E et al. AJR 2009;193:1340-1345

What are we doing ?
What can we do ?

- Iterative reconstruction
  - CT images are reconstructed from raw data
  - Reconstruction technique to lower image noise
  - Lower dose → same image quality
- Protocol adjustment
- Education of technicians, nurses, …
- Pressure on vendors
- Patient dose registration: required in future
- Awareness: "Image Wisely", "Dose watch", …

How low can we go ?

- ALARA - "As low as reasonably achievable"

  → all protocols

- Image quality standardization is difficult
- Radiologists want "nice looking images"
- Diagnostic performance *

  → no difference up to 50% dose reduction

  → at 30% → level of expertise becomes important

* D. Zhang
UCLA, 2010

Estimated radiation dose NLST and ITALUNG trial

Larke F, Kruger R et al. AJR 2011

NLST

- Study to determine the distribution of effective dose associated with single low-dose CT chest of average-size participants
- Average dose 1,4 – 1,6 mSv

  ←→ average dose standard

  chest CT 7,0 mSv

Mascalchi M, Mazzoni LN et al. Br J Radiol 2012

ITALUNG

- Four LDCT's + related further investigations (FDG PET and CT-guided biopsy)
- Mean effective dose to a single subject ranged between 6,2 and 6,8 mSv

http://www.xrayrisk.com/index.php — www.xrayrisk.com : Radiation Risk Calculator -- Calculate Radiation Dose and Cancer Risk

Google

Login

X-RAY RISK .com

Promoting responsible imaging through patient and provider education

FAQ of the Month

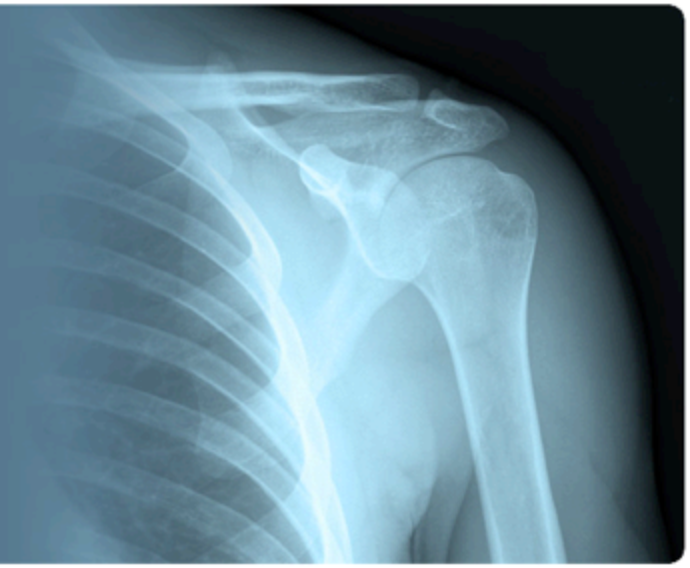
Are dental x-rays dangerous?

NOW AVAILABLE

FREE DOWNLOAD: Patient Radiation Handout

home | about | faq's | calculate your risk | glossary | contact

This site provides information for patients and health care providers to facilitate well-informed discussions about the increased risk of cancer from radiation exposure as a result of medical imaging.



CALCULATE YOUR RISK
Print an Individual Report

Refer this site | Site updated on 2012-09-28

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Vind ik leuk

262 personen vinden dit leuk. Wees de eerste

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Together, dedicated to improving the understanding of radiation risks from medical imaging. Calculate your dose and estimate cancer risk from

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X-RAY RISK

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through patient and provider education

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Are dental x-rays dangerous?

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Calculate your risk

Help

Plain Films (x-rays)

CT Scans

- Brain CT (Standard)
- Brain and Neck CTA/CTP
- Neck CT
- Chest CT (Low Dose Screening)
- Chest CT (PE Study)
- Chest CT (Standard)
- Cardiac CT (Coronary CTA)
- Cardiac CT (Calcium Scoring)
- Abdomen CT
- Abdomen CT (Dedicated Liver)
- Abdomen and Pelvis CT
- Chest, Abdomen and Pelvis CT
- Pelvis CT
- Virtual Colonoscopy CT
- Dental CT

Fluoroscopy

Nuclear Medicine

Interventional Procedures

MRI and Ultrasound

Please see Glossary for description of different studies.

Choose a study from the panels

Click on the panel titles to slide open additional studies.

http://www.xrayrisk.com/calculator/calculator-normal-studies.php — www.xrayrisk.com :

Reader

Google

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FAQ of the Month

Are dental x-rays dangerous?

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Risk Calculator

Help

Plain Films (x-rays)

- Chest x-ray (2 views)
- Abdomen x-rays
- Pelvis x-rays
- Hip x-rays (unilateral)
- Neck x-rays
- Upper Back x-rays
- Lower Back x-rays
- Extremity x-rays (Arm, Leg, etc)
- Mammogram (unilateral)
- Dental x-ray (panoramic)
- Dental x-ray (4 intraoral bitewings)
- Skull x-rays
- DEXA Scan (Bone Density)

Dose is based on multiple views

CT Scans

Fluoroscopy

Nuclear Medicine

Interventional Procedures

MRI and Ultrasound

Please see Glossary for description of different studies.

Study:	**Chest CT (Standard)**
Gender:	Male ○ Female ◉
Age at Time of Study:	34 (years)
Number of Exams:	1
Average Dose:	7.000 (mSv)
DLP (Optional for CT):	Optiona (mGy · cm)

Calculate

Total Effective Dose:	7	(mSv)
Additional Cancer Risk:	0.082	(%)
Baseline Cancer Risk:	37.5	(%)
Baseline + Additional Risk:	37.582	(%)

Add This Exam to your Report

To learn more about how these calculations are made, see the About page.

1 Online | Select Language | +1 | My Bookmarks | Send | Pin it! | Share | facebook | fwibiya

Your X-ray Risk Report

Study	Gender	Age	# of exams	Dose (mSv)	Additional Cancer Risk(%)	
Chest CT (Standard)	Male	34	1	7	0.055%	✕
		Totals:	**1**	**7**	**0.055%**	

Said another way, the chance of NOT getting cancer as a result of the above studies is 99.945%.

Save Report | Preview Report

Comparison Doses

Natural Background	3.1 mSv/year[10]	**Domestic Pilots**	2.2 mSv/year[11]
Average US Exposure	6.2 mSv/year[10]	**7 Hour Airline Flight**	0.02 mSv[12]
Chest x-ray (2 views)	0.10 mSv	**Chest CT**	7.0 mSv

Estimated Lifetime Risk of Death from Various Sources[13]

Motor Vehicle Accident	1% or 1 in 100 chances
Drowning	0.1% or 1 in 1000 chances
Bicycle Accident	0.01% or 1 in 10,000 chances
Lightning	0.001% or 1 in 100,000 chances

Keep in mind, the overall lifetime risk of developing an invasive cancer is 37.5% (1 in 3) for women and 44.9% (1 in 2) for men regardless of imaging history. These statistics are averages and do not predict what is going to happen to you. They do not take into consideration individual risk factors including lifestyle (smoking, diet, exercise, etc), family history (genetics) or radiation exposure. The majority of cancers occur later in life and the average lifetime risk of dying from cancer is 25% (1 in 4).

4. Lesion detection

Pulmonary nodules

=

Common incidental finding on CT

"What is so hard about finding a pulmonary nodule ? "

"It is not finding the nodule, but how you deal with the result."

J. Jelinek

Is low-dose as good as standard dose for detection of nodules ?

Detection: low-dose versus conventional CT

Rusinek H et al. Radiology 1998

Karabulut N et al. Eur Radiol 2002

Leader JK, Warfel TE et al. AJR 2005

Gierada DS, Pilgram TK et al. Radiology 2008

- High contrast between air and pulmonary parenchyma
  - → lung is well-suited for investigation with low-dose
- Sensitivities between low-dose and conventional images was not statistically significant
  - For detection
    - More likely to miss small nodules
  - For characterization
  - Reader variability

→ More studies needed !

Reader variability @ diagnosis

- Purpose of the study: to assess relative intra- and interobserver agreement in detecting pulmonary nodules when interpreting low-dose chest CT screening examinations
- Inconsistent measurements of nodule size
- Agreement is relatively low

Leader JK, Warfel TE et al.
AJR 2005

Gierada DS, Pilgram TK et al. Radiology 2008

Reader variability: What's the cause and what can we do to become better ?

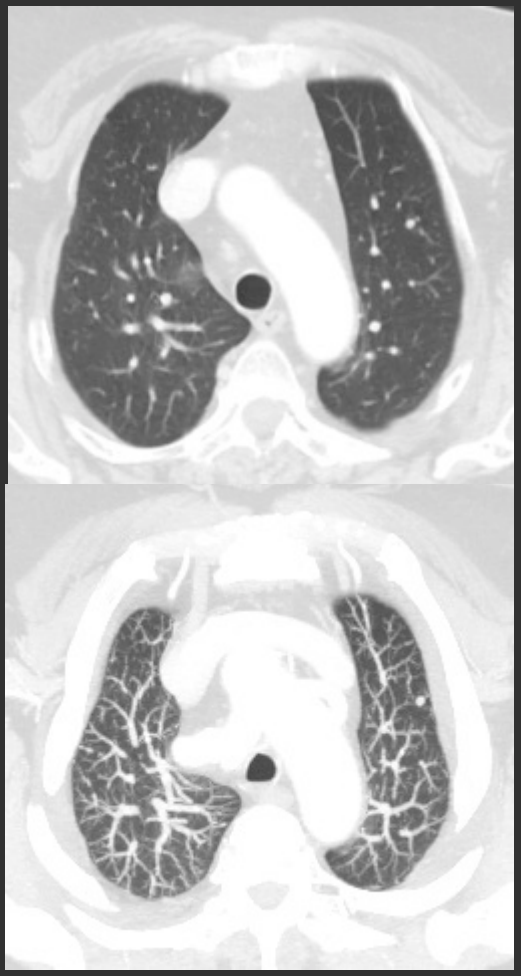
Nodule detection

Peloschek P, Sailer J et al.
Radiology 2007

Detection is mainly limited by visual perception problems and errors

1. Increasing number of transverse images
2. Anatomic noise (from normal structures in the lung parenchyma: vascular structures, airways, interstitium)
3. Human errors: interpretation mistakes, lack of concentration, disturbances, …

What can we do ?



- Cine review
  - Distinguishing nodules from vessels
- 3D data volume reconstruction
  - MIP reconstructions
  - MIP enhances nodule detection by more than twofold compared with the use of conventional transverse images

Coakley F, Cohen M et al.
Br J Radiol 1998

Peloschek P, Sailer J et al.
Radiology 2007

Is computer-aided detection (CAD) of any use ?

- Materials and methods: mainly 'standard' examinations – some low-dose
- General conclusion: "use of CAD system improved detection of pulmonary nodules"
- CAD algorithms can assist radiologists, but cannot replace them
- CAD as second reader ?
- Concerns
  - False-positives (COPD in screening population)
  - Not widely available
  - Time consuming

Rubin G, Lyo J et al. Radiology 2005

Awai K, Murao K et al. Radiology 2004

Beigelman C, Raffy P et al. AJR 2007

Girvin F, Ko J AJR 2008

Imaging in trials

NLST-trial

- Interpretations were made by using soft-copy display at lung and soft-tissue windows
- Without computer-assisted diagnosis

Rubin G, Lyo J et al.
Radiology 2005

Awai K, Murao K et al.
Radiology 2004

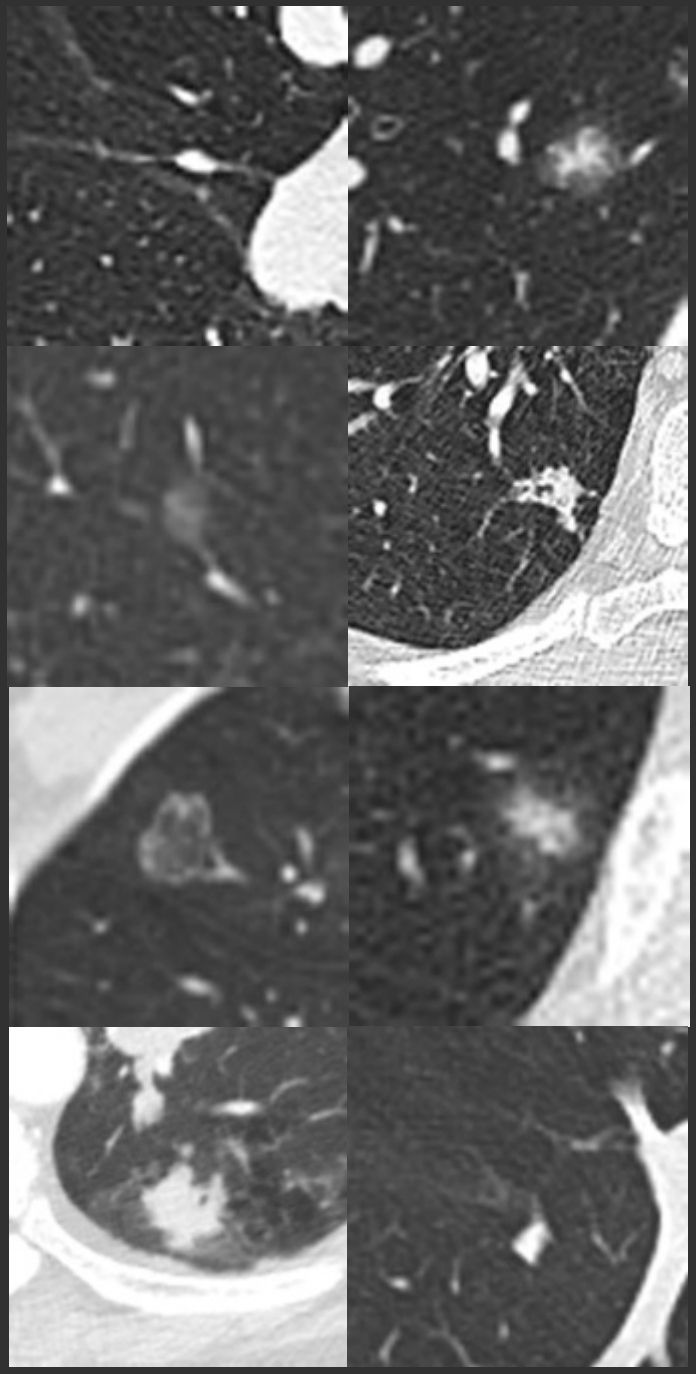
Beigelman C, Raffy P et al. AJR 2007

Girvin F, Ko J
AJR 2008

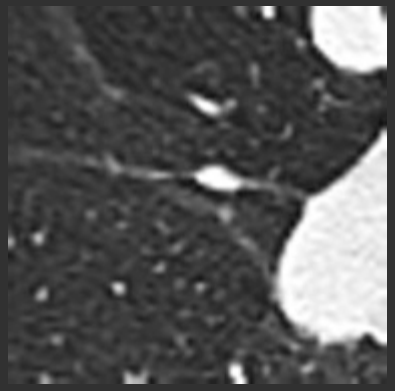
5. Lesion characterization

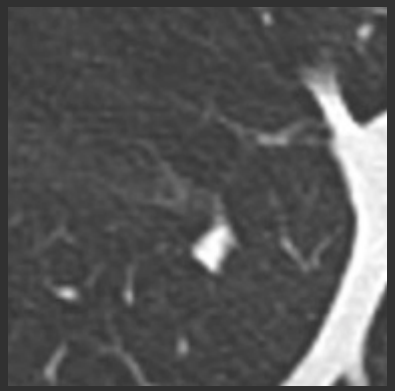
"All nodules are not equal"

The difficult part is to find the malignant one...



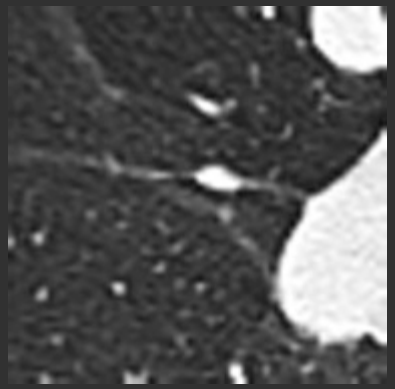
Benign
Probably benign
Probably malignant
Malignant

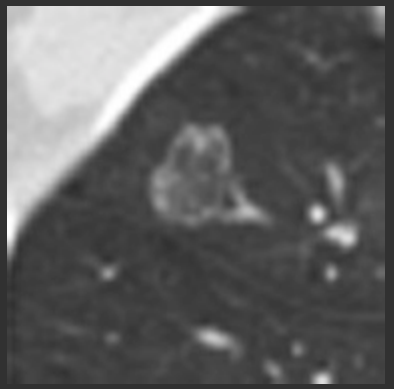


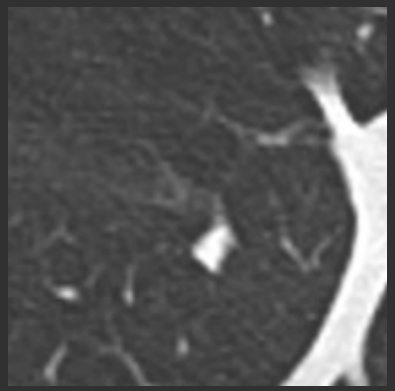


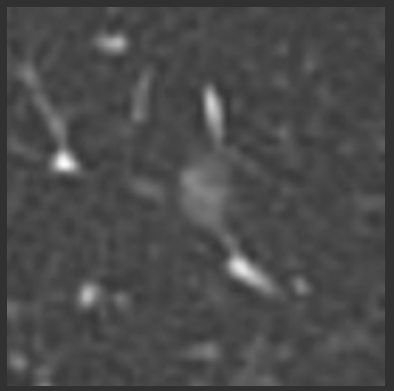
Benign

Solid - sharp
Polygonal







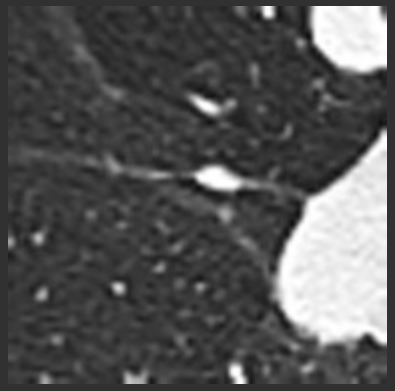


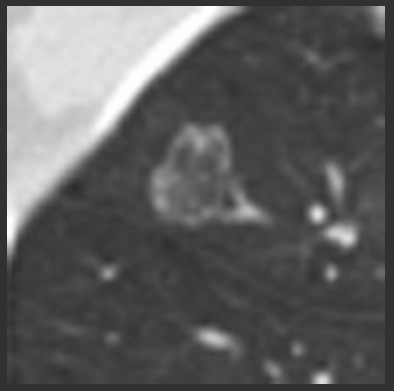
Benign

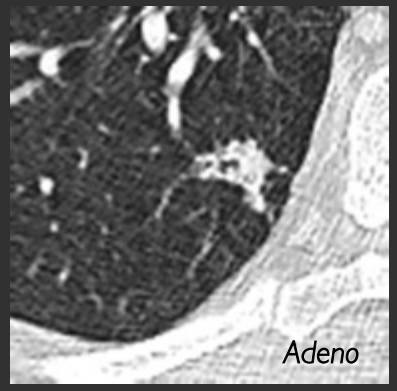
Solid - sharp
Polygonal

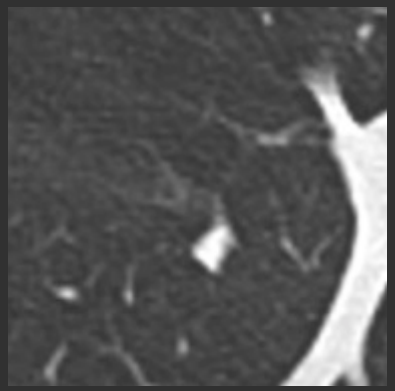
Probably benign

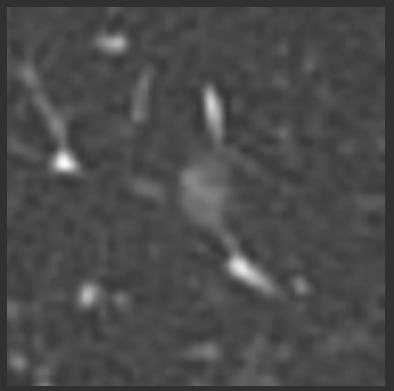
Ground glass

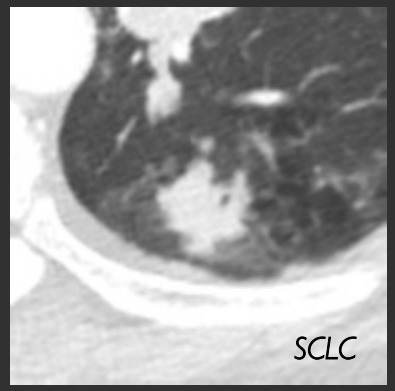












Benign

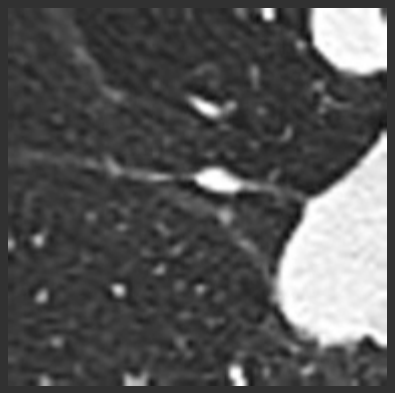
Solid - sharp
Polygonal

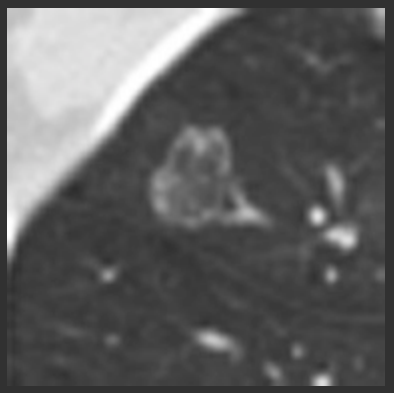
Probably
benign

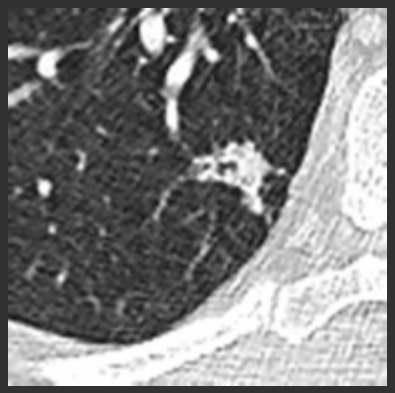
Ground glass

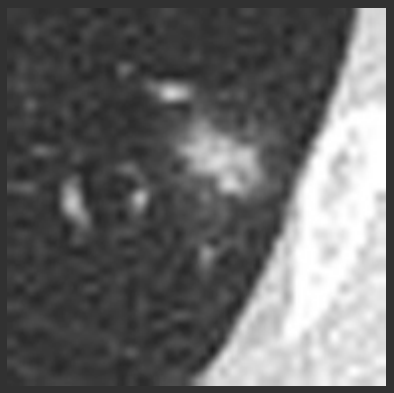
Probably malignant

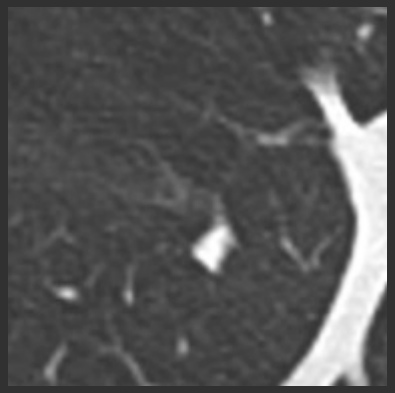
Solid
Spiculated

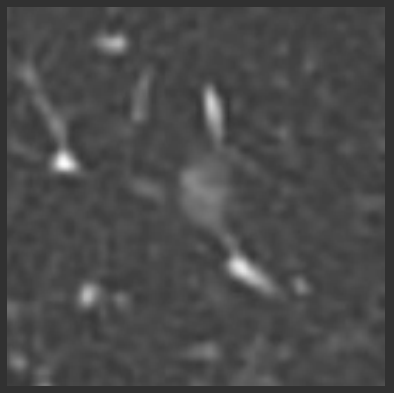


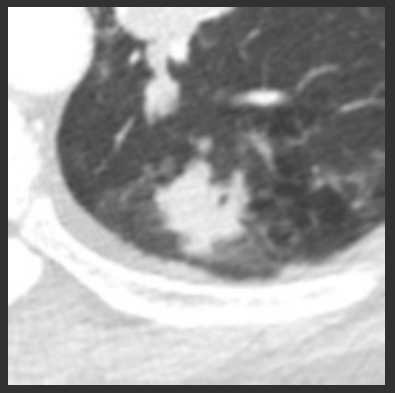


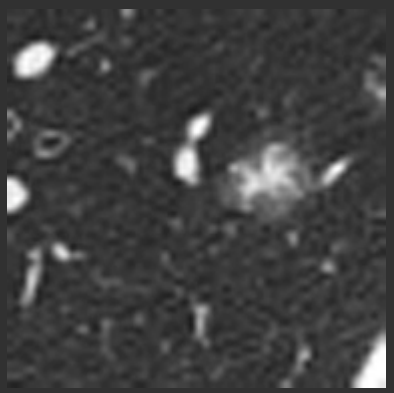












Benign

Solid - sharp
Polygonal

Probably benign

Ground glass

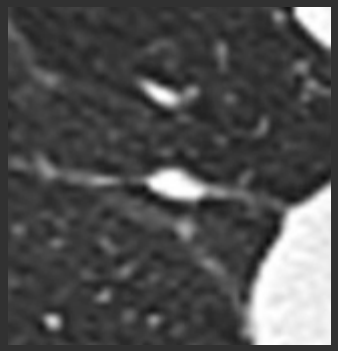
Probably malignant

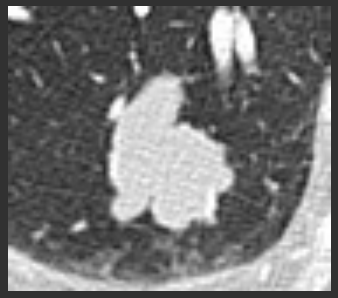
Solid
Spiculated

Malignant

Part solid

Characterization





1. Margin

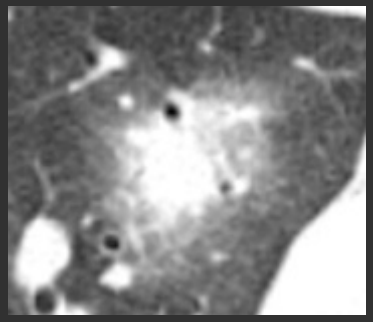
- Irregular or spiculated margins are highly suggestive
- Lobulation – smooth borders – pleural tail: both malignant and benign nodules

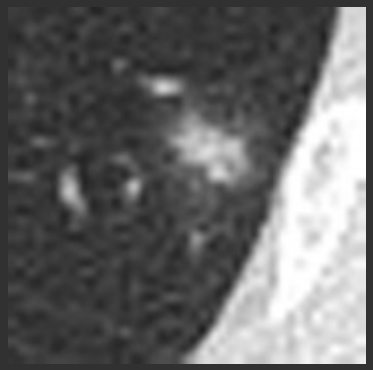
2. Halo sign

- Pathology: perinodular hemorrhage – tumor infiltration – inflammation
- More common in infection, but does not exclude malignancy

Characterization

1. Margin
   - Irregular or spiculated margins are highly suggestive
   - Lobulation – smooth borders – pleural tail: both malignant and benign nodules

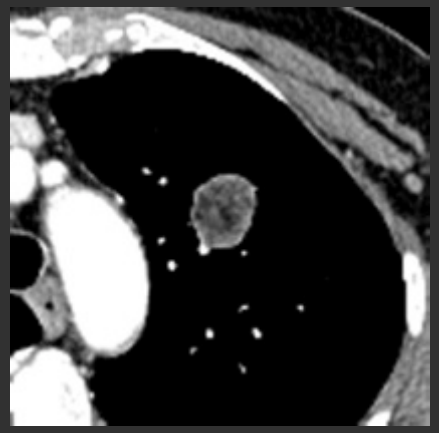




2. Halo sign
   - Pathology: perinodular hemorrhage – tumor infiltration – inflammation
   - More common in infection, but does not exclude malignancy

Characterization

3. Density and internal characteristics



- Macroscopic fat: benign lesions
- Cavitation: necrotic tumors – infectious and inflammatory lesions
- Calcification
  - Can be seen in 10% of patients with lung cancer
  - Benign patterns: laminated – central – diffuse – popcorn calcifications
  - Malignant patterns: stippled or eccentric

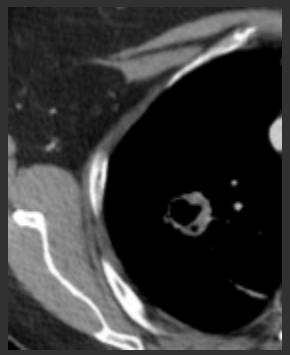
Girvin F, Ko JP
AJR 2008

Grewal RG,
Austin JH.
JCAT 1994

Characterization

3. Density and internal characteristics

Aspergillus



Wegener's

NSCLC

Candida

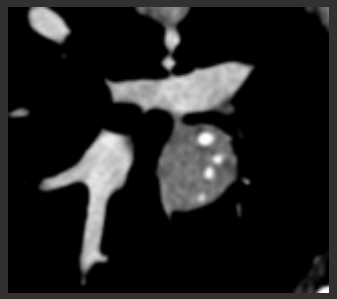
- Macroscopic fat: benign lesions
- Cavitation: necrotic tumors – infectious and inflammatory lesions
- Calcification
  - Can be seen in 10% of patients with lung cancer
  - Benign patterns: laminated – central – diffuse – popcorn calcifications
  - Malignant patterns: stippled or eccentric

Girvin F, Ko JP
AJR 2008

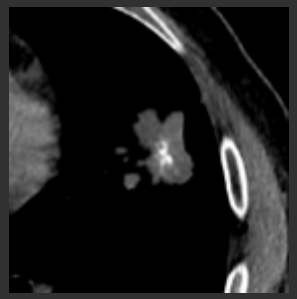
Grewal RG,
Austin JH.
JCAT 1994

Characterization

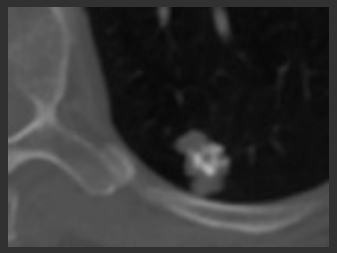
3. Density and internal characteristics



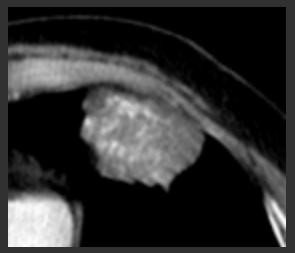
Papillary thyroid carcinoma



Primary lung carcinoma



Hamartoma



Mucinous metastasis

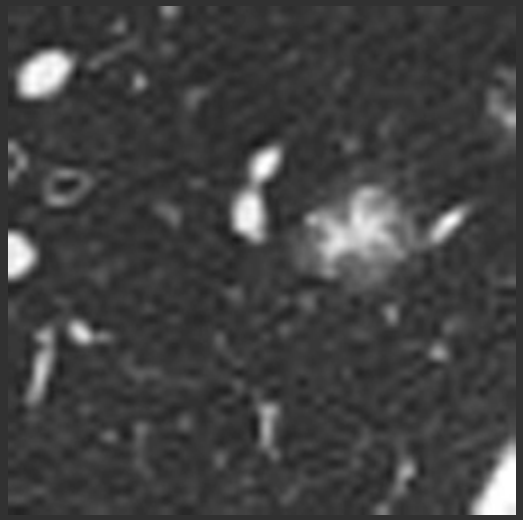
- Macroscopic fat: benign lesions
- Cavitation: necrotic tumors – infectious and inflammatory lesions
- Calcification
  - Can be seen in 10% of patients with lung cancer
  - Benign patterns: laminated – central – diffuse – popcorn calcifications
  - Malignant patterns: stippled or eccentric

Girvin F, Ko JP
AJR 2008

Grewal RG, Austin JH
JCAT 1994

Characterization

3. Density and internal characteristics



- Subsolid nodules
  - Solid nodules with component of ground glass
  - Higher incidence of malignancy compared to ground glass nodules
  - Bronchoalveolar growth pattern

Girvin F, Ko JP
AJR 2008

Grewal RG,
Austin JH.
JCAT 1994

Characterization

4. Nodule size and measurement

- Risk of malignancy is strongly correlated with size
- Up to 42% of nodules smaller tham 5 mm can be malignant*
- "Guidelines for management of small pulmonary nodules detected on CT scans: A statement from the Fleischner Society"

Recommendations for Follow-up and Management of Nodules Smaller than 8 mm Detected Incidentally at Nonscreening CT

Nodule Size (mm)*	Low-Risk Patient†	High-Risk Patient‡
≤4	No follow-up needed§	Follow-up CT at 12 mo; if unchanged, no further follow-up‖
>4–6	Follow-up CT at 12 mo; if unchanged, no further follow-up‖	Initial follow-up CT at 6–12 mo then at 18–24 mo if no change‖
>6–8	Initial follow-up CT at 6–12 mo then at 18–24 mo if no change	Initial follow-up CT at 3–6 mo then at 9–12 and 24 mo if no change
>8	Follow-up CT at around 3, 9, and 24 mo, dynamic contrast-enhanced CT, PET, and/or biopsy	Same as for low-risk patient

Note.—Newly detected indeterminate nodule in persons 35 years of age or older.
* Average of length and width.
† Minimal or absent history of smoking and of other known risk factors.
‡ History of smoking or of other known risk factors.
§ The risk of malignancy in this category (<1%) is substantially less than that in a baseline CT scan of an asymptomatic smoker.
‖ Nonsolid (ground-glass) or partly solid nodules may require longer follow-up to exclude indolent adenocarcinoma.

*Ginsberg et al. Radiology 1999

Grewal RG, Austin JH. JCAT 1994

Girvin F, Ko JP AJR 2008

PULMONARY NODULE FOUND ON X-RAY OR CT[1] ≥ 35 YRS OF AGE

MGH NODULE MANAGEMENT

COMPARE WITH OLD STUDY CXR OR CT

- If growth, consider Diagnostic Intervention PNAB[5] or VATS[6]
- Solid nodule, No growth > 2yr[12] → No action[2]

NO STUDY AVAILABLE → CT

- Benign calcification or fat → No action[2]
- Nodule, any size

No history of malignancy within last 5 years[11,12,13]

≤4mm	>4-6mm	>6-8mm	>8mm
High-Risk Patient[7,10] Initial follow-up CT at 12 months; If unchanged, no further follow-up	**High-Risk Patient**[7,10] Initial follow-up CT at 6–12 months then at 18–24 months if no change	**High-Risk Patient**[7,10] Initial follow-up CT at 3 months then at 9 and 24 months if no change	Consider PNAB[5], VATS[6] or PET[4] Attention to part solid/ ground glass nodule[3]
Low-Risk Patient[8,10] No follow-up needed[9]	**Low-Risk Patient**[8,10] Initial follow-up CT at 12 months; if unchanged, no further follow-up[3]	**Low-Risk Patient**[8,10] Initial follow-up CT at 6–12 months then 18–24 months if no change[3]	**High-Risk Patient**[7,10] If co-morbidities and PET(-) consider follow-up after 3, 9 and 24 months
	Ground Glass Nodule[2] Initial scan at 3 months then as above and then yearly for at least 3-5 years	**Ground Glass Nodule**[2] Initial scan at 3 months then as above and then yearly for at least 3-5 years	**Low-Risk Patient**[8,10] If co-morbidities and PET(-) consider follow-up at 3, 9 and 24 months[3]
			Ground Glass Nodule[2] Initial scan at 3 months then as above and then yearly for at least 3-5 years

- If growth, consider Diagnostic Intervention PNAB[5] or VATS[6]
- If no growth, No action

History of malignancy within last 5 years[12]

Follow-up CT at 3,6,12 and 24 months or according to clinical protocol

If growth,consider Diagnostic Intervention PNAB[5] or VATS[6]

Suspect Infection, Immunocompromised/or fever[12]

Short term follow-up, ≤ 4-6 weeks and to resolution

Or consider Diagnostic Intervention PNAB[5], Bronchoscopy or VATS[5]

If lesion resolves, No action

FOOTNOTES

1. An incidental pulmonary nodule is defined as a rounded opacity in the lung <3cm in size. The recommendations refer to solid pulmonary nodules unless otherwise specified. Nodule measurements are obtained in the long axis.
2. Non-solid (ground glass) nodules may require longer follow-up to exclude indolent adenocarcinoma.
3. Part solid / part ground glass nodules may be more aggressive carcinomas and may require earlier diagnostic intervention.
4. Bronchioloalveolar carcinomas (BAC), well-differentitated adenocarcinomas, and tumors <8mm may be FDG-PET(-). Granulomatous and inflammatory lesions may be FDG-PET(+).
5. Percutaneous needle aspiration biospy (PNAB)
6. Video assisted thoracoscopic surgery (VATS)
7. History of smoking or of other known risk factors, including lung cancer screening patients
8. Minimal or absent history of smoking and of other known risk factors
9. The risk of malignancy in this category (<1%) is substantially less than that in a baseline CT scan of an asymptomatic smoker.
10. MacMahon H et al. Fleischner Society Statement on CT Small Pulmonary Nodules. Radiology 2005; 237:395-400.
11. The NLST Team. Reduced Lung Cancer Mortality with Low-Dose CT Screening. N Engl J Med 2011;365:395-409.
12. All follow-up imaging intervals are measured from the baseline scan timepoint.
13. Follow-up CT scans may be preformed with low dose CT protocols.

Characterization

4. Nodule size and measurement

- Studies: interobserver agreement was moderate to substantial
- Similar for positive and negative interpretations
- Disagreement → variation in measurement
- Interobserver variability: baseline examinations and follow-up examinations

Erasmus et al.
J Clin Oncol 2003

Bogot NR et al.
Acad Radiol 2005

Gierada DS et al.
Radiology 2008

Singh S, Pinsky P et al.
Radiology 2011

Interpretation of low-dose CT

Gierada DS et al. Radiology January 2008

- Radiologists involved in NLST
- Interpretation of low-dose CT as baseline NLST scan
  - Longest transverse dimension of non-calcified nodules larger than 4 mm
  - And recommendation for follow-up of positive cases
- Conclusion
  - Interobserver agreement was moderate to substantial
  - Similar for positive and negative interpretations
  - Disagreement → variation in measurement

Erasmus et al.
J Clin Oncol 2003

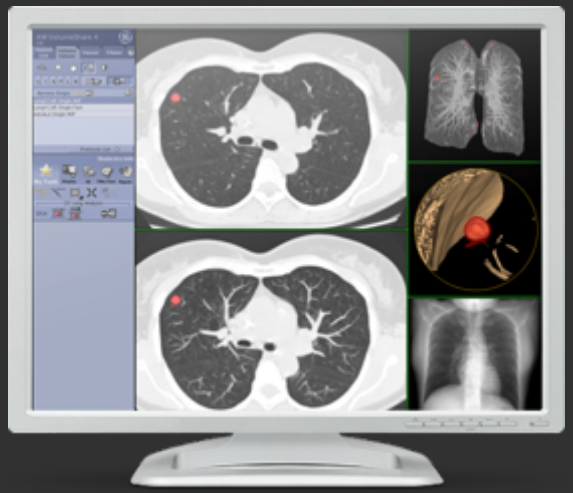
Bogot NR et al.
Acad Radiol 2005

How good are radiologists in detecting and characterizing pulmonary nodules ?

...There is room for improvement...

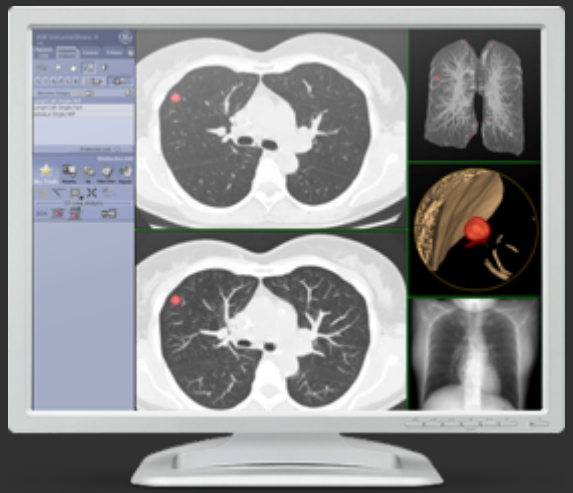
Nodule growth = 3D process
Future: use of 3D measurement methods
→ computer aided detection
→ volumetric determination of lesion size

Volumetric measurement

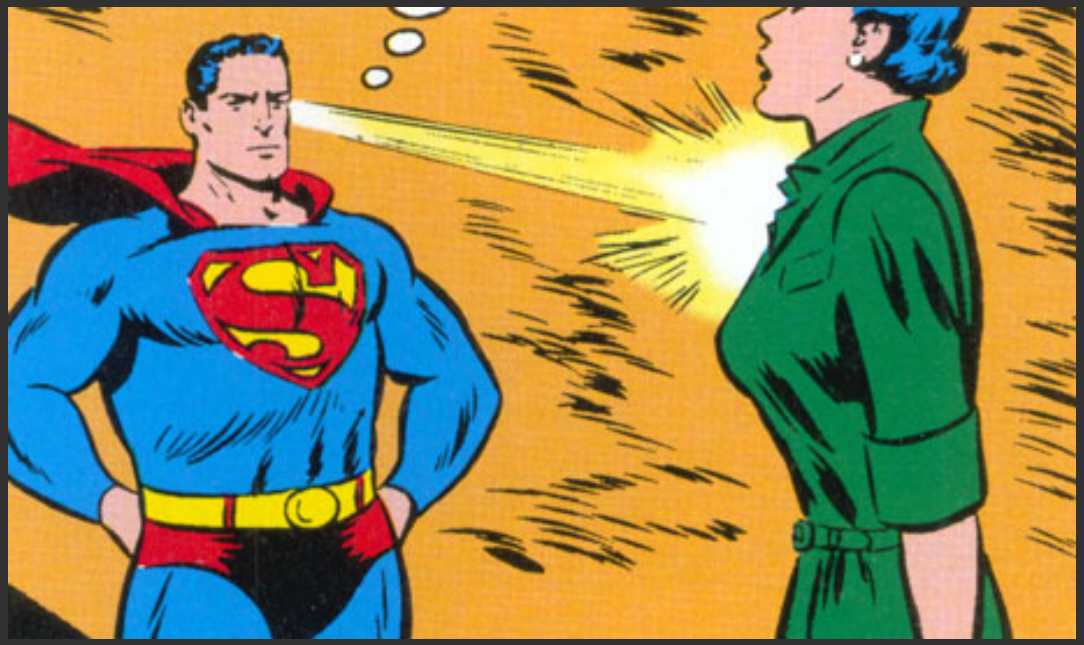


- 3D techniques are susceptible to precision error
- Important factors:
  - Nodule size
    - Small lesions → higher error
  - Shape
    - Spiculated lesions = difficult
  - Attenuation
    - Segmentation problems

Volumetric measurement

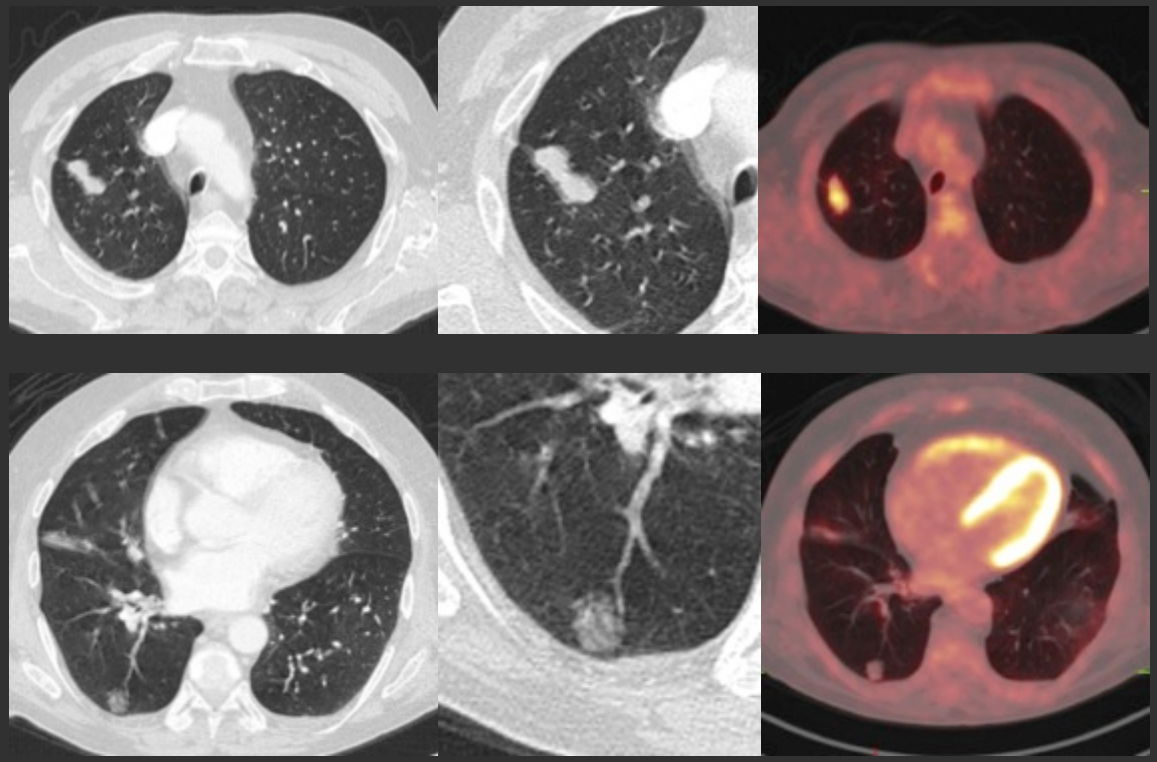


- *Goodman et al. AJR 2006*
  - Lung nodule volumes in patients scanned three times in the same session
  - Interscan volumetric variation of 20%
- *Boll et al. AJR 2004*
  - Cardiac gating
  - Small nodules near the heart: 34% volume change during cardiac cycle
- *De Hoop et al. Radiology 2010*
  - Mass measurements can enable detection of growth of ground glass nodules
  - And are subject to less variability than are volume or diameter measurements

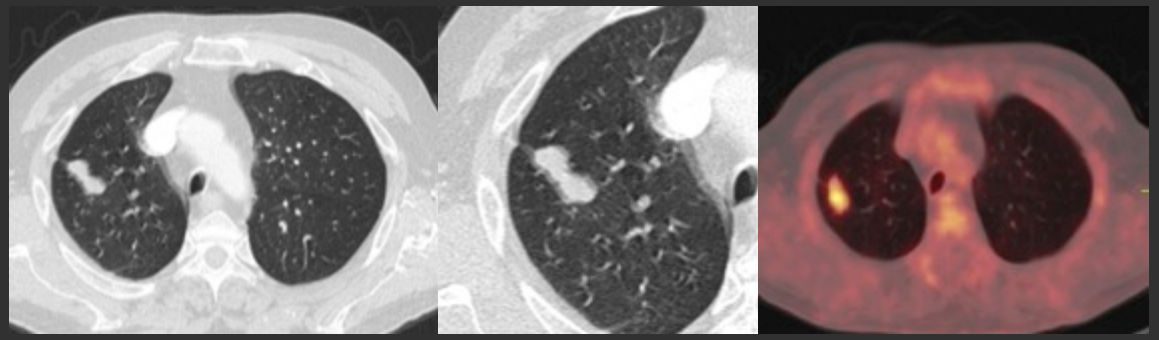



ISOTOPE MAN TO THE RESCUE
CHALK RIVER
MACKAY

73-y-old man
Dyspnea
No previous history

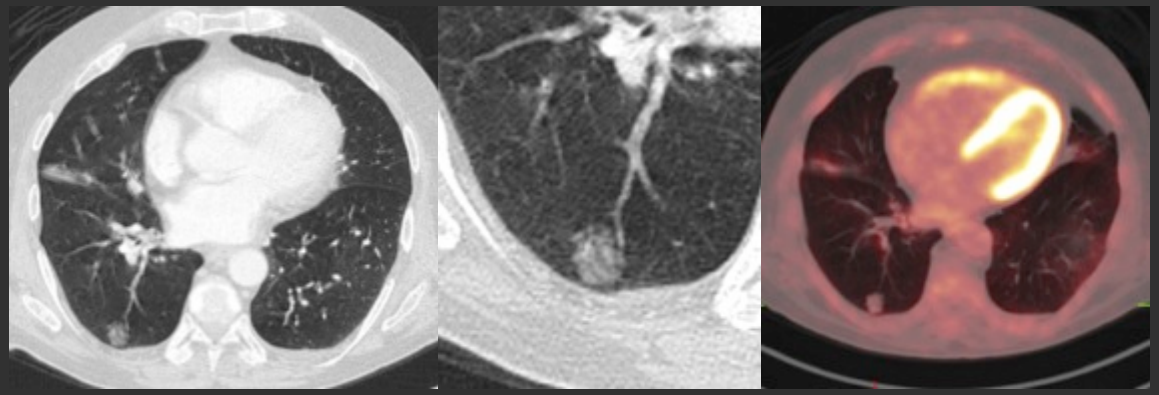


73-y-old man
Dyspnea
No previous history



PET + lesion

Pathology
GRANULOMA

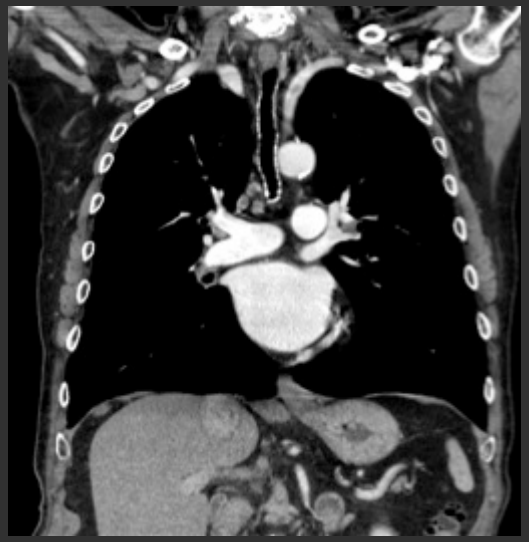


PET - lesion

Pathology
ADENOCARCINOMA

6. Extrathoracic findings

Extrathoracic findings



- Detection of incidental findings outside the lung
- NLST 7,5% → clinically significant abnormality
- Danish Lung Cancer Screening trial
  - In 6,8 % of patients
  - 7,7% of these findings were malignant
- Health benefits ←→ additional diagnostic examinations / procedures with no health benefit
- Difficult interpretation on low-dose CT

Saghir Z et al.
Am J Respir Crit Care 2012

7. What do radiologists think about lung cancer screening ?

National survey of radiologistq

"The use of CT for Screening: A National Survey of Radiologists' Activities and Attitudes" – Radiology 2008

- 398 US Radiologists – 1/3 reading screening examinations
- Responding to physician and patient requests are more important motivations for reading CT screening studies than the belief that patients benefit from screening
- Most radiologists are in favor of lung cancer screening, while few support whole-body CT imaging
- Radiologists are significantly more likely to believe CT screening studies are appropriate if they read them than if they do not

Some final thoughts...

A lot of work is done

…

A lot of work still needs to be done

The interpretation of pulmonary findings is a complex task

…

with room for improvement in both lesion detection and characterization.

Radiation dose and dose reduction – as low as reasonably achievable – is important

…

and should concern every radiologist.

Management of the pulmonary nodule requires a multidisciplinary approach.

Thank you for your attention