Reply to letter to the editor regarding “prevalence and variability in reporting of clinically actionable incidental findings on attenuation-correction CT scans in a veteran population”

We greatly appreciate Drs. Lee and Delaney's thoughtful comments regarding our article “Prevalence and Variability in Reporting of Clinically Actionable Incidental Findings on Attenuation-Correction CT Scans in A Veteran Population”.¹ The primary finding from our project was that clinically significant incidental findings on CTACs are common, and there is considerable interobserver disagreement between cardiology-trained and radiology-trained physicians in identifying them, especially for pulmonary nodules. We completely agree that this discordance represents an important gap in our current practice and warrants initiatives to assure adequate training requirements and reporting standards for interpreting CTACs. This is underscored by other studies demonstrating adverse prognosis amongst patients with major extracardiac findings on CTAC,² further highlighting the need for accurate identification. Consistent with this, we implemented radiology interpretation of all CTACs in our center and believe this practice could be adopted more broadly in settings where primary cardiology readers lack experience or training in chest CT interpretation.

While past guidelines have generally advised reporting of incidental findings, recently published SPECT guidelines provide no specific recommendations for interpreting CTAC.³ However, although current IAC Standards and Guidelines for Nuclear/PET Accreditation mandate interpreting physicians have ≥ 4 months (COCATs level 2) training in nuclear cardiology, the COCATs 4 training guidelines recommend level 3 with additional training beyond the standard 3-year clinical cardiology fellowship for performing and interpreting hybrid SPECT/CT and PET/CT imaging.⁴ Unfortunately, these guidelines provide no specific recommendations regarding training in noncardiac CT

interpretation. We speculate that most cardiologists interpreting nuclear perfusion imaging in the US lack formal training in noncardiac CT interpretation.

With regard to the higher number of pulmonary nodules reported by cardiologists in our study, we suspect this reflects the lack of formal radiology training and the better discriminatory ability of the radiologist. There may have also been a systematic referral bias as the cardiologists were aware a radiologist was over-reading the exams and our study population is at increased risk for lung cancer.

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