

## Classification of HRCT for Occupational and Respiratory Diseases (3). ■

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**Author disclosures** are available with the text of this letter at [www.atsjournals.org](http://www.atsjournals.org).

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## References

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- 2 National Institute for Occupational Safety and Health. Coal workers' health surveillance program-chest radiograph classification form-CDC 2.8. Morgantown, WV; 2020.
- 3 Kusaka Y, Hering KG, Parker JE. International classification of HRCT for occupational and environmental respiratory diseases. Tokyo, Japan: Springer; 2005.

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## Reply: Radiologic Classification of Black Lung: Time for a New Gold Standard?

*From the Authors:*

We thank Lynch and colleagues for their response to our study (1). Although the authors do not address the key findings of the study regarding the role of financial conflicts of interest among physicians involved in the Federal Black Lung Program, they do reiterate some of the concerns we discussed in the manuscript. We address each of their points sequentially below:

1. They note that there was disagreement on 20.7% of the claims but do not mention that thousands of these claims involved substantial disagreement in which one B-reader reported an absence of pneumoconiosis whereas a second indicated high-profusion simple pneumoconiosis (2/1 to 3/+ ) or progressive massive fibrosis. This indicates that one of the physicians misses or fails to indicate the presence of any classifiable parenchymal abnormalities. It is possible that the revised International Labor Office (ILO) classification guidelines will reduce this type of discordance.
2. The authors note a concern we raised in the manuscript that if a classification “did not fit the desired narrative, [it] would not have been included in the claim.” The U.S. Department of Labor (USDOL) noted that legal teams, in particular those hired by employers, may withhold classifications deemed unfavorable to their legal case. To address this, USDOL passed a rule requiring disclosure of all solicited classifications to uncover suppression of medical evidence.
3. The authors assert that radiologists are more qualified with digital imaging and post-processing than other physicians. All

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currently practicing B-readers use digital imaging in their practices and must pass the same examination and recertification process, which involves a digital syllabus and examination. Regardless, the distribution of radiologists and other specialties was consistent across major categories of financial affiliations (Table 1) and controlling for specialty in the models did not impact the conflict of interest odds ratios.

4. There are guidelines that have been instituted to improve uniformity in classification of radiographs through the National Institute for Occupational Safety and Health B-reader training program, certification examination, and use of ILO standard images. These processes are designed to reduce discordant reads. However, B-reading training and ILO guidance clearly state that if a miner has a known history of significant exposure to coal dust and has opacities consistent with pneumoconiosis, then the radiograph should be classified as coal workers' pneumoconiosis, unless there is a clear alternative explanation.
5. It is commendable that they raise the issue that employers have significantly greater financial resources to contest claims. Although it is legal for employers to pay for the best defense possible, the system is not equitable, and employers have a clear advantage.
6. High-resolution computed tomographic imaging proposed by the authors currently does not have validated standard images or a system of testing and training that is analogous to the ILO classification system. The authors assert that this new technology, together with a panel, would potentially resolve discordant medical opinions. However, panels frequently experience political pressures, gridlock caused by split decisions, and recurring vacancies that impact the minimum quorum needed and can be intentionally understaffed by the administration in power.

What does concern us is the failure by the authors of this letter to acknowledge the core findings relating to the strong association between the direction of ILO classifications and the financial

affiliation of B-readers or the recommendations to improve transparency, oversight, and objectivity in classifications. The authors also fail to note the evidence showing a change in behavior by physicians hired by employers. Our findings demonstrate that B-readers ever hired by employers were substantially more likely to classify an absence of pneumoconiosis on classifications not part of the initial examination compared with initial classifications paid for by USDOL (90.2% vs. 77.2%). This change in behavior was not observed among physicians ever hired by the miner. ■

**Author disclosures** are available with the text of this letter at [www.atsjournals.org](http://www.atsjournals.org).

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### Erratum: Supplementation with Iron in Pulmonary Arterial Hypertension: Two Randomized Crossover Trials

The authors of “Supplementation with Iron in Pulmonary Arterial Hypertension: Two Randomized Crossover Trials”, published in the June 2021 issue of *AnnalsATS* would like to make a correction to their article (1). The original text in the RESULTS section, Study 1 subsection reads “Ferinject was tolerated, and no serious adverse events were reported. Phosphate concentrations, which can fall in the first 2 weeks after ferric carboxymaltose, remained in the normal range throughout (Figure E5).” This text should be changed to “Phosphate concentrations can fall in the first 2 weeks after ferric carboxymaltose. Asymptomatic hypophosphataemia was recorded in 6 out of 15 patients with blood samples available 2 weeks after Ferinject; this was judged as clinically significant in 2 patients. There was no difference between Ferinject and placebo treated groups at

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- 1 Friedman LS, De S, Almberg KS, Cohen RA. Association between financial conflicts of interest and International Labor Office classifications for black lung disease. *Ann Am Thorac Soc* 2021;18:1634–1641.

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treatment cross over (Figure E5). A full list of adverse events is available on [clinicaltrials.gov](http://clinicaltrials.gov) (NCT01447628).” For the convenience of our readers, *AnnalsATS* is replacing the online version of the article with a corrected version. ■

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