HHS Public Access

Author manuscript

J Occup Environ Med. Author manuscript; available in PMC 2021 May 27.

Published in final edited form as:

J Occup Environ Med. 2020 May ; 62(5): e235. doi:10.1097/JOM.0000000000001837.

Response to 'Follow-Up of the Libby, Montana Screening Cohort:

A 17-year Mortality Study: Likely Underestimation of Nonmalignant Asbestos-Related Disease'

Theodore C. Larson, MS,

Division of Toxicology and Human Health Sciences Agency for Toxic Substances and Disease Registry Atlanta, Georgia

Laura Williamson, MPH,

Montana Department of Public Health and Human Services Miles City, MT

Vinicius C. Antao, MD, PhD

Center for the Advancement of Value in Musculoskeletal Care Hospital for Special Surgery New York, NY

Reply:

We thank Drs Miller, Loewen, Szeinuk, and Noonan for their comments and insights regarding the burden of asbestos-related disease (ARD) among current and former Libby residents, as well as on our publication.[1] We agree with Dr Loewen's observation that local physicians may not have noted ARD in this cohort of screening participants. This could have resulted in under-ascertainment of nonmalignant, ARD mortality. (Note that we reported results for asbestosis, a nonmalignant disease defined as interstitial pneumonitis and fibrosis caused by inhalation of asbestos.[2]) Still, the asbestosis SMRs we reported ranged from 82 (among workers categorized as "other asbestos occupation") to 558 (among household contacts) in comparison with a national reference population. These SMRs clearly indicate a striking excess of nonmalignant ARD in the screening cohort.

We also agree that the results from our analysis only represent the cohort of participants in the Agency for Toxic Substances and Disease Registry and Montana Department of Public Health and Human Services screening programs; across the decades in which the Libby vermiculite operation was active, there were likely other persons exposed to Libby amphibole asbestos who did not participate in those screening programs (possibly due to, as suggested, out-migration from Libby, or other factors).

Address correspondence to: Theodore C. Larson, MS, Agency for Toxic Substances and Disease Registry, Atlanta, Georgia (thl3@cdc.gov).

The findings and conclusions in this report are those of the author(s) and do not necessarily represent the official position of the Agency for Toxic Substances and Disease Registry.

The authors report no conflict of interest.

We further agree that mortality studies in general benefit from pairing death certificate data with objective clinical measurements. In this case, expert interpretations of chest radiographs were available for the majority of participants. As noted, CT has greater sensitivity than chest radiographs to asbestos-related changes,[2] but were not used in our analysis due to CT data being unavailable for the majority of the screening cohort.

Finally, that the majority of the cohort may have been too young (more than 50% were younger than 50 years of age at the time of screening) to have developed ARD indicates that continued monitoring of Libby residents and further mortality updates should be considered to detect trends in ARD. The continued work of Drs Miller, Loewen, Szeinuk, and Noonan and others offers insights about the natural history of disease among Libby patients.

REFERENCES

1. Larson TC, Williamson L, Antao VC. Follow-up of the Libby, Montana Screening Cohort: a 17-year mortality study. J Occup Environ Med. 2020;62:e1–e6. [PubMed: 31714372]
2. Society AT. Diagnosis and initial management of nonmalignant diseases related to asbestos. Am J Respir Crit Care Med. 2004;170:691–715. [PubMed: 15355871]