Authors Response to Comments on the Creswell et al Paper—Too Soon to Breathe Easy

We appreciate the questions raised by Dr Rosenman,[1] who we know has extensive experience in the field of occupational health, and we wholeheartedly agree with his point about the need to continue considering asbestos-related conditions in differential diagnoses at the clinic level.

With regards to our recent paper,[2] Dr Rosenman has two specific points for which he is requesting further explanation.[1] The first concerns our suggestion that there might be "underreporting or misclassification of race and ethnicity" in our data. He points out that there has long been a history of discrimination within trade unions, which could easily lead to fewer non-white individuals having industrial exposures to asbestos. We appreciate his bringing up this important point and referring readers to work on this topic. It is certainly possible that racial discrimination in union membership has contributed to the disproportionately white and non-Hispanic composition of Wisconsin's asbestosis cases. However, we also believe that our original statement is not without merit. There are more sources of asbestos exposure than just industrial union work and there is evidence that race and ethnicity are often misreported in medical records.[3] Moreover, even other state-level datasets are not immune from misclassification. We cite a Wisconsin-specific example of racial misclassification in the Wisconsin Cancer Registry[4]—even though registries are among the most accurate and complete datasets available.[3] Additionally, Wisconsin has a somewhat fragmented system of vital records reporting and we mention in the paper that legislation was recently passed "requiring the [Wisconsin] Department of Health Services to establish and encourage best practices for coroners and medical examiners."[5] As such, it is not unreasonable to think that misclassification or underreporting of race and ethnicity could exist in our data. We would also like to highlight that our statement was made in the limitations section of the paper and is not presented as a finding of our study. That said, we appreciate the counterevidence that Dr Rosenman has presented, and his point is well taken. We welcome this discussion as part of our field's ongoing efforts to improve the reporting of race and ethnicity data and to better contextualize findings on race and ethnicity within a nuanced social determinants of health framework.

Dr Rosenman's second point is with regard to our inclusion of the ICD-10-CM code J92.0, which is specific to "pleural plaque with presence of asbestos." His concern is that the lumping together of a parenchymal condition with a condition of the pleura provides suboptimal information to the clinical audience. We appreciate his concern on this point and believe that future work could consider these separately as well as together. Our paper, however, was approaching this topic through the lens of public health surveillance and the broader question of asbestosis prevalence was our main focus. From that perspective, whether asbestos fibers are in the soft tissue of the lungs or have penetrated deeper into the pleura was believed to be of less consequence than restricting our sample to those with asbestosis diagnoses.

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Declaration of conflicts of interest: Dr Creswell, Dr McCoy, and Mr. Morris have received travel support to attend meetings of the Council for State and Territorial Epidemiologists (CSTE).

Ethical Considerations & Disclosure(s): These analyses use administrative data taken from statewide public health surveillance systems. As such, individual informed consent and IRB approval were not required or obtained. These analyses were performed as part of the authors' normal duties as members of the State of Wisconsin's public health workforce. This work conforms to the principles delineated in the Declaration of Helsinki. The authors have made every effort to preserve confidentiality, including suppressing counts in tables when <5 individuals are represented.

Drs Creswell, McCoy, Modji, and Mr Morris conceptualized the purpose and created the plan for this analysis. Dr Creswell conducted the primary analyses and drafted the manuscript. Drs. McCoy, Modji, Bedno, and Mr Morris provided feedback on analysis and contributed to manuscript writing, editing, and draft finalization.

The data used are the property of the Wisconsin Department of Health Services. Raw data are not publicly available, but data summaries may be available upon request.

EQUATER Network checklists are not applicable for this submission.

Generative technology (aka. "Artificial intelligence" or "AI") was not used for any part of this work including, but not limited to, hypothesis generation, data collection, data evaluation, and manuscript preparation.

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