such risk-mitigating actions as CT screening and smoking cessation.

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Reply to the Editor:

We thank Drs Young and Hopkins for their kind remarks in favor of the American Association for Thoracic Surgery guidelines for lung cancer screening with low-dose chest computed tomographic scans. In creating guidelines on the basis of a successful research protocol, the Association chose to expand the age of the screening population beyond the ages of the participants in the National Lung Screening Trial.¹ The rationale behind this decision included the age distribution of the disease in North America, the fact that increasing age is an independent risk factor for development of cancer, and the improvement in

quality life years expected up to the 9th decade of life. Drs Young and Hopkins offer additional justification for this guideline, namely the age-specific lung cancer mortality in the United States increases exponentially after the age of 50, with a peak at the age of 80 years.

We envision a Web-based program that would allow each citizen to calculate his or her own absolute risk of lung cancer, dissemination of easily updated educational materials, and potential data collection for specific populations. It is our hope that such risk assessment would in turn lead to risk modification and smoking cessation as integrated components of patient care. Personal risk calculators are currently available, but they are not easily accessible to the public. Such a Web-based tool might convert a guideline or instruction into a conversation between physician and patient, including the opportunity to further patient interest in smoking cessation.

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CORRECTION OF FAULTY ASSUMPTIONS IN COST-EFFECTIVENESS ANALYSIS To the Editor:

We read with interest the Canadian cost-effectiveness analysis by Doble and colleagues¹ comparing transcatheter aortic valve replacement (TAVR) with standard management (SM) for inoperable patients and with surgical aortic valve replacement (SAVR) for high-risk patients with severe,

operable aortic stenosis. Although we found many aspects of this work to be well done, we believe that the published analysis contains a few important factual errors and a few assumptions that have been contradicted by recently published follow-up data from the PARTNER trial.

First, the Sapien valve (Edwards Lifesciences LLC, Irvine, Calif) price in Doble and colleagues' analysis¹ (\$37,606) is \$13,606 greater than the current Canadian price of \$24,000 (all figures are in Canadian dollars). With no other changes to the model of Doble and colleagues,¹ correction of the Sapien valve price would make TAVR slightly cost saving (by \$2453) relative to SAVR in high-risk surgical patients and would reduce the incremental cost-effectiveness ratio for TAVR relative to SM from \$36,458 to \$20,497 per life year gained (or from \$51,324 to \$29,037 per quality-adjusted life year gained). Second, Doble and colleagues¹ estimated the costs of SAVR in Ontario from provincial data for patients aged 70 years and older in Case Mix Group (CMG) 165, cardiac valve repair. SAVR procedures are not coded under this CMG in Ontario, however, but rather under CMG 162 (cardiac valve replacement), which has slightly higher reimbursement. More importantly, we believe that "average" reimbursement values for SAVR in patients aged 70 years and older are likely to underestimate the true costs of SAVR among patients like those in the PARTNER trial, whose baseline characteristics in the clinical trial placed them in the highest 5% to 10% of predicted operative risk.²

In projecting survival for inoperable patients, Doble and colleagues¹ used Canadian life table data for years 2 through 20 of their model for both TAVR and SM patient cohorts. This approach assumes that survivals beyond 1 year would be similar for the two groups, in essence ignoring the