characterized UIP from surgical or explanted lung specimens, features specific for UIP such as a patchwork pattern of interstitial fibrosis, fibroblastic foci, and honeycomb change\textsuperscript{2,3} are readily recognizable in many TBB specimens.\textsuperscript{5} We agree that in these small specimens one may not identify discordant pathology. However, since the prognosis associated with “discordant” or “concordant” UIP is the same, recognizing the UIP findings will dictate the ultimate prognosis.\textsuperscript{4} We believe that these finding are quite important and should be considered as a step forward, not backward as suggested by Mulderhjee and Spiteri. Unfortunately, it has become widely accepted, despite a lack of convincing evidence, that TBBs are not useful in diagnosing idiopathic interstitial pneumonias. However, if in the future TBBs are proven to be useful in diagnosing UIP from a pool of patients with diverse diffuse lung diseases, many unnecessary surgical lung biopsy procedures, with the associated morbidity, mortality, and cost, could be prevented.\textsuperscript{5} Our study plants the seeds for what could turn out to be a very important step forward in the field.

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Harm From Spirometry?

To the Editor:

The recent editorial by Enright (April 2006),\textsuperscript{1} and his rhetorical title, prompts this reply. Dr. Enright cites a carefully done Italian study\textsuperscript{2} that fails to prove that spirometry done by primary care physicians improves the diagnosis of asthma or COPD. In fact, this study\textsuperscript{2} was inconclusive but did serve to demonstrate some of the barriers to the widespread use of office spirometry, which I have commented about elsewhere,\textsuperscript{3} along with the benefits. Dr. Enright fears that spirometry will cause big pharmaceutical companies to promote inhalers more vigorously than without spirometry. Is there evidence to support this contention?

About 30 years ago, I wrote an editorial in CHEST\textsuperscript{3} advising the early diagnosis of COPD. This was after the successful follow-up of a prevalence study\textsuperscript{4} for COPD that showed a high mortality over 7 years in patients with airflow obstruction.

In the 3 decades that have followed, the monumental Lung Health Study\textsuperscript{5–7} has shown that the adverse course and prognosis of early stage COPD can be greatly improved through smoking cessation up to 14.5 years of follow-up. Thus, it is clear that knowledge of an abnormality in spirometry results, followed by smoking cessation, does identify a population at high risk in whom intervention can be successful. Survival was convincingly improved in quitters!

But does performing spirometry improve smoking quit rates other than in a National, Heart, Lung, and Blood Institute trial? Two old studies\textsuperscript{5,8} strongly suggest that community screening does just this. More smokers with the knowledge of airflow obstruction quit than if they had abnormal airflow, but both groups moved away from smoking!

Other studies\textsuperscript{8–10} have also shown that spirometry can help quit rates when COPD is first diagnosed as a result of spirometry. In these studies,\textsuperscript{9,10} the spirometry was done in special laboratories and not by primary care physicians. Office spirometry has been shown to increase the diagnosis of COPD in general practice.\textsuperscript{11} However, another recent study\textsuperscript{12} showed little benefit from an instruction period and the providing of free spirometers and supplies, plus advice on reimbursement in primary care physicians’ offices. Thus, controversy continues.

My conclusion remains that spirometry is effective in smoking cessation, but we need to find better ways to promote this simple test in doctors’ offices. This is the goal of the National Lung Health Education Program, which was launched a decade ago.\textsuperscript{13,14} Failure to achieve our goals thus far should only increase our efforts to succeed. We have the need, the simple tools, and the goal of reducing the impact of COPD. We just need to do it!

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