Open Pulmonary Biopsy

To the Editor:

The 11 authors of "Open Pulmonary Biopsy: Nineteen-Year Experience with 416 Consecutive Operations," which appeared in the January 1976 issue (Chest 69:43-47, 1976), said that their indication for biopsy was the presence of a clinical and radiologic diagnosis of diffuse pulmonary disease undiagnosed by indirect methods. In the one tabulation contained in the article, the 39 patients with bronchogenic carcinoma are difficult for me to fit into their protocol. Similarly, the inclusion of eight cases of pulmonary infarction diagnosed by lung biopsy makes one think that the adjective, "diffuse," was employed rather broadly. Since it seems that there was not strict adherence to the protocol, the 11 cases of histo-

plasmosis arouse curiosity. One wonders if included in the 11 were examples of (1) acute infiltration of one or two pulmonary segments, (2) acute diffuse reticulonodular disease, (3) acute multifocal nodular densities, and (4) single or multiple calcified lesions, all of which are usually self-limited processes requiring no specific treatment.

As in histoplasmosis, rarely is it necessary to resort to lung biopsy to establish a diagnosis of farmer's lung. In the report by Ray et al, 64 instances of farmer's lung are listed as having been diagnosed by lung biopsy.

It is also a little unsatisfying, considering the fact that Ray et al tout the specificity of biopsy information, that in the tabulation, two of the neoplastic diagnoses were listed as "other," while nine of the occupation-related diagnoses, four of the diagnoses of specific infections, and 38 of the specific histologic diagnoses were described as "miscellaneous." Furthermore, if you count diagnoses of "chemical inhalation," "acute bronchiolitis," and "arteri-

olar occlusion" as specific, the reader can still discern only 241 specific diagnoses (58 percent) among the 416 cases mentioned in the tabulation.

Even when some details of individual cases are given, one is kept in suspense about the diagnosis established. I would wager that even those "few internists" who "still pursue the elusive diagnosis of diffuse pulmonary disease down the winding avenues of lupus erythematosus prepar-

ations, endless sputum cultures, and repeat chest x-ray films" would want to read the diagnosis in one of the patients who died within 24 hours after biopsy. He was the 80-year-old man who had malignant hypertension, a recent myocardial infarction, and renal failure, as well as diffuse pulmonary disease.

In the 19 patients (4.5 percent) who died after biopsy, only four had their therapeutic management altered because of the histologic diagnosis provided by the biopsy. Ray et al state that it was of value to the family to know, rather than not know, a specific histo-

logic diagnosis. Because of probable misapplication of their protocol and the incomplete presentation of data, I cannot gauge whether the quality of information gained by biopsy verifies such rhetoric as that and the follow-

ing: "open-lung biopsy is a true bargain . . ." and " . . . it allows and promotes early and definitive diagnosis and prompt therapy." Nevertheless, Ray et al should be given credit for a responsive interdisciplinary approach to a difficult problem and for the wisdom of the final sentence in their article (the Latin word, "ultimare," means "to come to an end, be last").

REFERENCE