a significant number of bronchoscopic procedures, had been included in the survey, the results may have differed." According to our experience, differences may relate to the quality, rather than the quantity, of the procedures.

Between January 1979 and December 1991, 19,974 bronchoscopic procedures were performed at our institution (Table 1). Of these, 11,185 (56 percent) yielded a lung cancer and 7,380 (37 percent) either no pathologic signs or benign lesions, including chronic bronchitis, endobronchial tuberculosis, and benign tumors. The remaining 1,389 (7 percent) were therapeutic bronchoscopic procedures (Nd:YAG laser bronchoscopy included).

From the thoracic surgeon's standpoint, the practical interest of bronchoscopy lies in its predictive value. That is, the endoscopic review must help the surgeon anticipate the extent of the parenchymal resection. To do so, the surgeon must keep in mind the clinical staging and match it with the bronchoscopic findings, the histologic diagnosis, and the patient's functional reserve. Accordingly, whenever a suspected lesion is seen at bronchoscopy, we are accustomed to evaluate it in terms of "endoscopic surgical adequacy." In other words, we try to understand (1) whether the lesion is amenable to resection, (2) what is the least amount of parenchyma to be sacrificed, and (3) whether there are signs of nodal involvement. In our practice, standard additional diagnostic procedures are added to bronchoscopy in order to achieve reliable responses.1

The endoscopic surgical adequacy was a reliable predictor of resectability of a visible endobronchial lesion in 63 percent of our cases. Metastatic disease and poor functional reserve were the main reasons for surgical ineligibility. Hence, training and competence in bronchoscopy may deal with something more than the "numbers game."

Every single case is a distinct clinical entity that represents a challenge for the thoracic surgeon who is expected to provide cure. Consequently, 50 or more bronchoscopic procedures per year may not be sufficient to ensure competence; much more important would be "the performance of the procedure on a regular basis," which, in our experience, is crucial to fruitful training. We believe that a thoracic surgeon must be a proficient and competent bronchoscopist if he wants to give optimal patient care.

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Utilization of the Peak Expiratory Flow Rate in Evaluation of Acute Dyspnea of Cardiac or Pulmonary Origin

To the Editor:

I read with interest in the January 1992 issue of Chest the article by McNamara and Cioni1 on using peak expiratory flow rates (PEFRs) in the emergency department (ED) to differentiate between cardiac and pulmonary dyspnea. While I certainly agree with the utility of PEFRs in the ED, in our institution we find a directed history and an abbreviated physical examination (searching in the latter particularly for stigmata of either process, such as "barrel chest" or dependent edema), a brief review of the patient's prescribed medications, and an expeditious portable chest radiograph to be at least as helpful as peak flow measurement in differentiating between congestive heart failure (CHF) and acute exacerbations of chronic lung disease (CILD). Ambiguous cases (a group that includes patients in whom both disease processes are active) can be safely managed empirically with low-flow supplemental oxygen until these quick diagnostic maneuvers can be completed. In most EDs, a chest radiograph can be rapidly performed and will provide an accurate working diagnosis in these patients. If immediate therapy is necessary, a selective ß1-agonist aerosol treatment and/or a small dose of a loop diuretic would be safe in essentially all patients.

Our ED experience with asthmatics and patients with CILD leads us to disagree with the authors' claim that absolute PEFRs provide more immediate clinically useful data than percent predicted PEFRs.1 Our respiratory technicians can convert an absolute PEFR to a percent predicted PEFR within 30 s—certainly quickly enough that patient care is not compromised. Furthermore, at least in our
population, both body habitus and degree of effort expended in PEFR measurement vary widely among patients. We have found that percent predicted PEFRs are much more useful for the individual patient, both in assessing progress of therapy and in objectively comparing severity of respiratory distress with that on previous ED visits. Indeed, even the primary supporting study cited by the authors, that by Nowak et al., cautioned that patients with a body habitus falling outside the norm may benefit from percent predicted PEFR calculation.

In summary, the article by McNamara and Cionni, while suggesting an interesting use of objective data (PEFR), suffers somewhat from its lack of emphasis on other useful information that may be expeditiously obtained in the ED on patients in respiratory distress, namely, clinical and radiographic data. Patients with features of both CHF and CLD may be initially managed without a clear differentiation between the two. In addition, we have had good success with the routine use of percent predicted PEFRs in our ED, and we recommend their use in this setting.

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REFERENCES

To the Editor:

Dr. Pollack’s remarks are welcome and deserve comment. It is agreed that the history, physical examination, chest radiograph, and medication history are very valuable tools for the clinician in differentiating CHF from acute exacerbations of CLD. The PEFR determination should be viewed as an adjunct to these steps. Previous literature and common experience indicate the potential for confusion of the diagnoses as certain findings overlap, including peripheral edema, jugular venous distention, and the presence of wheezing. Our own study indicated that the medication history alone could not correctly classify 44 percent of the study group. Certainly, as Dr. Pollack states, a chest radiograph is invaluable; however, in many hospitals, especially at night (when many of these patients present), there can be substantial delays in obtaining this study. Additionally, the stimulus for this study was, depending on our results, to eventually examine the usefulness of the PEFR in the prehospital setting, where diagnostic difficulty has been previously documented and where chest radiographs are unavailable.

The suggestion that ambiguous cases be managed with low-flow oxygen and the “safe” combination therapy of a selective β2-agonist and a small dose of loop diuretic is somewhat problematic. Our patients were significantly ill, since the entry criteria included a rating of moderate or severe dyspnea by the physician. They therefore required more aggressive therapy than the above cautious approach. Low-flow oxygen to a patient severely dyspneic from CHF would be dangerous, and most physicians, despite the higher beta-2 selectivity of newer agents, would prefer to avoid undue cardiac stimulation of the patient in CHF. Similarly, a “small dose” of a loop diuretic would have been useless in our CHF patients, and most would want to avoid unnecessary fluid losses in CLD patients. In stable patients with milder dyspnea, if the diagnosis is in doubt, rather than treat both CHF and CLD, a more extensive evaluation including chest radiography can be initiated prior to therapy.

I have no doubt that percent predicted PEFRs are purer and more useful than absolute PEFRs, but certain factors led us to report and to clinically use absolute PEFRs. First, at our institution and many others, there is no respiratory technician immediately available to the emergency center and, as mentioned previously, the ultimate goal of this research was to enhance prehospital care, as well as emergency center care.

In closing, our article only suggests the utility of the PEFR as an aid to diagnosis. This utility may be enhanced in situations where the chest radiograph is delayed or unavailable.

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Methotrexate and Asthma

To the Editor:

Methotrexate has been recommended as an effective and safe glucocorticosteroid-sparing agent in “steroid-dependent” asthma. Nevertheless, its efficacy remains controversial.

We report the case of a 54-year-old woman with a history of well-controlled asthma, whose respiratory symptoms reappeared while receiving methotrexate therapy. She was a nonsmoking housewife and had no previous relevant medical background. She was hospitalized on two occasions in 1985 for acute crises, and received oral prednisone from November 1985 to March 1986. Her status dramatically improved while receiving inhaled therapy (salbutamol, disodium cromoglycate, and beclomethasone three times a day), which was progressively reduced and eventually stopped in June 1990. She then remained asymptomatic with regular normal spirometric checks from October 1986 to January 1991. In February 1990, the diagnosis of seronegative rheumatoid arthritis was made, and methotrexate therapy, 10 mg/wk, was instituted. In spite of this treatment, there was a recurrence of the asthmatic symptoms in January 1991, necessitating the reintroduction of inhaled therapy (salbutamol, disodium cromoglycate, and beclomethasone). There was no evidence of interstitial lung disease induced by methotrexate. The patient has been asymptomatic again since September 1991, and her FEV1 is 2.280 ml (0.920 ml predicted). However, she needs regular treatment; otherwise, breathlessness reappears.

Commenting on a unique case report of a patient suffering from rheumatoid arthritis, Jones and associates supported the idea that weekly low-dose methotrexate therapy could induce clinical and laboratory features of asthma. In our report, it is not possible to determine whether the recurrence of clinical and spirometric signs of asthma experienced by the patient was simply related to the course of the disease itself, or whether it was induced by methotrexate therapy, as suggested by Jones et al. This raises again the question of guidelines for monitoring asthmatic patients whose condition worsens during methotrexate therapy. Methotrexate in our case was unable to prevent recurrence of chest symptoms,