We have found only one reference in the literature to Tru-cut lung biopsy in a case of BOOP. We consider that when the clinical situation suggests BOOP and transbronchial biopsy has not led to a definitive diagnosis, the performance of percutaneous Tru-cut biopsy may make thoracotomy unnecessary.

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Perivascular Fibrosis of Muscular Pulmonary Arteries in COPD

To the Editor:

The article by Andoh and colleagues, which appeared in the December 1992 issue of Chest, is a useful addition to the literature on cor pulmonale in COPD. Its contribution to the larger understanding of COPD would be considerably enhanced if some additional information could be provided.

What is the frequency in the investigators' population of chronic bronchitis patients similar to those reported? My own experience and the literature suggest that such cases are rare. It would be helpful to know the time taken to accumulate these six cases and the total number of cases of chronic bronchitis and emphysema studied over this time period.

Three of the six subjects with chronic bronchitis were nonsmokers. Did these subjects have other risk factors for COPD, such as a dusty occupation or onset of symptoms after acute viral illness? Were lifetime smoking histories similar in the three ex-smokers in the chronic bronchitis group and the six in the emphysema group?

The authors say that autopsy "confirmed the absence of emphysematous changes" in the chronic bronchitis cases. It would be helpful if some objective evidence of this were given, such as a semiquantitative estimate of the amount of emphysema observed in the inflation-fixed specimens or a mean linear intercept measurement on the histologic sections.

The investigators say that all subjects died of cor pulmonale and respiratory failure. However, no information is given from the autopsies about right ventricular anatomy. It would be helpful to know the ratio of right ventricular to left ventricular plus septal wall weight, or if that measure is not available, the heart weight and right and left ventricular wall thicknesses.

It is only from the information requested that one can make a judgment as to whether these cases are rare examples of "pure" chronic bronchitis with perivascular fibrosis and cor pulmonale or whether they fall into the group of "increased-marking emphysema."

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To the Editor:

In Japan, chronic bronchitis with severe obstruction and without emphysema is found in nonsmoking adults. This is a progressive lung disease with a poor prognosis and is frequently accompanied by Pseudomonas aeruginosa infection, showing diffuse linear and reticulonodular shadows on the chest radiograph. It has been called diffuse panbronchiolitis by Homma et al and has not been reported in white patients.

The clinical features resemble those found in adult patients with mild cystic fibrosis (CF), an inherited disorder in white persons but with minimal or little pancreas dysfunction and intermediate-range sweat chloride concentration. Although Sugiyama et al have implicated a genetic background for this disease, our results based on delta F508 mutation analysis of the CF gene indicate that the chronic bronchitis may represent a disease different from CF.

Thus, in Japan, pure chronic bronchitis with severe obstruction and without pulmonary emphysema is very common. The pathologic findings of this type of chronic bronchitis are well described in many previous reports in English that show the absence of emphysema and changes in spite of severe obstructive impairment and right ventricular hypertrophy. As pointed out by Dr. Snider in his comment on our report, such pure chronic bronchitis is rare in the United States and European countries. However, this chronic bronchitis is a good clinical model for understanding the bronchial or airway lesions in COPD because of the absence of pulmonary emphysema. The obtained findings will also be useful for the management of COPD patients in the United States and European countries.

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