REFERENCE

To the Editor:

The analysis that we performed was a retrospective analysis to examine whether there was any difference in mortality between patients who were treated with Nd:YAG laser therapy vs patients who were treated with Nd:YAG laser therapy and brachytherapy. We stated, "Because of the retrospective nature of this study, information such as the degree of airway obstruction, computed tomographic evaluation of the malignant neoplasm, and pre- and posttherapy pulmonary function was either not routinely reported, not obtained, or not available for evaluation, and therefore not included in this study" (Chest 1993; 103:1028-31).

Endobronchial brachytherapy was given as a form of palliation in conjunction with Nd:YAG laser therapy in an attempt to maintain airway patency, and thereby relieve the respiratory discomfort of the patients. In addition, it has been suggested by Schray et al1 that the response to Nd:YAG laser lasted longer when Nd:YAG laser therapy was followed by brachytherapy, but no study directly comparing the two modalities had been performed.

We did not imply that endobronchial brachytherapy should be administered to all patients with exophytic lesions. In this study, all patients had already received the maximum amount of external beam irradiation and the goal of therapy with Nd:YAG laser and brachytherapy was only for the purpose of palliation of respiratory symptoms.

We do not think that definite recommendations regarding the use of Nd:YAG laser and brachytherapy can be made based on retrospective data available and that further multicenter prospective studies are needed to determine if brachytherapy and Nd:YAG laser therapy offers a survival benefit for this group of patients over Nd:YAG laser therapy alone.

Jeffrey M. Shea, M.D.; Roblee P. Allen, M.D.; R. Steven Thurratt, M.D., F.C.C.P.; and Allan D. Siefkin, M.D., F.C.C.P., Division of Pulmonary and Critical Care Medicine, University of California, Davis Medical Center, Sacramento, California

REFERENCE

Needle Aspiration Biopsy and Ultrasonic Guidance

To the Editor:

We read with interest the report by Pan et al,1 which appeared in the May 1995 issue of Chest. They performed ultrasound-guided percutaneous transthoracic biopsy in 14 patients with lung mass with central necrotic area, and obtained adequate biopsy specimens in all cases. They concluded that lung biopsy under sonographic guidance is a useful tool to avoid false-negative biopsy specimens in malignant tumors. Our experience is substantially consistent with such results. We performed ultrasound-guided fine-needle aspiration biopsy (FNAB) in 64 patients with pulmonary lesions in contact with pleura. Fifty-six of these masses were shown to be malignant tumors, and in 11 of them CT-scan showed internal liquefaction necrosis. The FNAB was diagnostic in 58 cases comprehensively, with a sensitivity of 90.6 percent and a specificity of 100 percent, and allowed to obtain adequate biopsies in 10 masses with necrotic center (90.9 percent).

In our opinion, sonographic guidance is preferable to CT or fluoroscopically guided biopsy, even though the diagnostic accuracy is similar.2 In fact, ultrasound guidance is less expensive and less time-consuming than CT and offers the important advantage of real-time monitoring of the needle position. On the other hand, unlike fluoroscopy, it can disclose the presence of liquefaction necrosis inside the lesion and allows the identification of lesions not detectable by lateral fluoroscopy because of overlapping structures.3 It neither exposes the patient nor the physician to ionizing radiation and can be performed when the patient is seated. For all these reasons, we think that transthoracic biopsy of pulmonary masses has to be always performed under ultrasound guidance, and not only when central necrosis is present, provided that the lesion is in contact with pleura or an acoustic window is available. Moreover, according to Pan et al4 and in our opinion, CT scan of the chest is not a prerequisite procedure of ultrasound-guided transthoracic biopsy.

Biopsy specimens resulted inadequately in five patients (necrosis in one case, blood in four). Other authors5,6 have shown that such drawbacks can be reduced by using a rapid cytologic staining which allows an immediate assessment on biopsy material, if it results inadequately. FNAB can be repeated immediately. We think that such a procedure should be routinely used when pulmonary transthoracic biopsies are taken, whatever guidance is used.

Lucio Trecisani, M.D., Sergio Sartori, M.D., Stefano Putinati, M.D., and Vincenzo Abbasciano, M.D., Department of Internal Medicine; and Pier Marco Cerri, M.D., Department of Radiology, S. Anna Hospital, Ferrara, Italy

Reprint requests: Dr. Trecisani, Via Briosi 172/D, 44100 Ferrara, Italy

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