


To the Editor:

I appreciate the comments by Dr. Zalcman and his colleagues in response to our article (Chest 1993; 104:362-65). In general, I agree with them in that PCR sequencing is time-consuming and laborious and that ELISA assay would be suitable as a routine clinical test. However, before it is used as a routine test, the following questions should be answered.

(1) Does the presence of anti-p53 antibody perfectly correspond with the presence of p53 mutations? Are there some classes of mutations that are somewhat more antigenic than the other?

(2) Does the presence of the anti-p53 antibody reflect the immunologic response of the host to the cancer cells? It would be worth testing if patients with cancer with positive anti-p53 antibody have a better prognosis than those without this humoral response? If this is proven, then this test would be of a prognostic value rather than of a diagnostic value.

(3) Are a small number of cancer cells that can be cured by conventional therapy enough to evoke an antigenic response?

In relation to the third question, we were impressed that two patients with anti-p53 antibody who had been originally referred for benign pulmonary diseases later developed lung cancer.

Dr. Zalcman’s work is worthy to be tested by many other laboratories to establish clinical usefulness. We would also like to examine the anti-p53 antibody in our cohorts, when we have a chance.

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Simpler Is Not Always Better

To the Editor:

We read with interest the comprehensive literature review by Torén et al entitled “Asthma and Asthma-Like Symptoms in Adults Assessed by Questionnaires: a literature review. Chest 1993; 104:600-08” and the work by Schlichtholz et al “The immune response to p53 in breast cancer patients is directed against immunodominant epitopes unrelated to the mutational hot spot. Cancer Res 1992; 52:6380-84”

To the Editor:

We agree with Denis Charpin and Daniel Verloot that preferring a gold standard when validating asthma-related questions is a problem. As we pointed out in our review, future studies of validations must be performed against clearly stated definitions of asthma, including both clinical physiologic findings and a history. A simple question like “physician-diagnosed” asthma will have rather low sensitivity. There are, of course, situations where high sensitivity is preferred, for instance when different work places are screened with the intention of identifying as many subjects as possible with occupational asthma. In such situations, the use of “physician-diagnosed” asthma is inappropriate.

In studies of the etiology of a rare disease such as asthma, however, high specificity is (799 percent) crucial. Low specificity (<99 percent) generates a large number of false-positives, ie, the positive predictive value will be low. This will underestimate the risk-estimates.