their national priorities with acceptable differences in some of the still controversial points. However, there were some topics that should have some coincidences, such as the optimal peak expiratory flow (PEF) used when deciding a patient's discharge from the emergency room (ER). It was amazing to realize that the percent predicted PEF value recommended to decide discharge from the ER varied from 50 to 75% (Argentinean 60%, British 75%, Canadian 50%, American 70%). There was no mention of acute asthma management in the Australian report. For a patient with a predicted PEF of 600 L/min, the Canadian physicians would discharge at a PEF of 300 L/min and the British doctors would not discharge until 450 L/min. In this way, the hospitals in Great Britain would be crowded by asthmatics that could be treated at the ambulatory setting. On the other hand, asthmatics from Canada were at a higher risk of relapse. Which PEF is the best PEF for deciding discharge? There is some evidence, although weak in nature, that supports the 60% of predicted PEF as the best value.

In a review of management of acute life-threatening asthma, an FEV\textsubscript{1} of at least 60% of predicted has been suggested as the cutoff point between discharge and admission. In another study, the patients without relapse had been discharged with an FEV\textsubscript{1} of 1,879 mL ± 110 (SE), that was about 60% of the predicted FEV\textsubscript{1}. Finally, it appears that a 60% of predicted PEF value was the more reasonable PEF if the correlation between FEV\textsubscript{1} and PEF was accepted. We further need to test prospectively the guidelines to ensure that we are going in the right direction.

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REFERENCES
4 Guidelines on the management of asthma. Thorax 1993; 48(suppl 1):S1-S24
8 Nowak RM, Pensler MJ, Parker DD. Comparison of peak expiratory flow and FEV\textsubscript{1}: admission criteria for acute bronchial asthma. Ann Emerg Med 1982; 11:64-69

Obstructive Lung Disease Percutaneous Needle Biopsy

To the Editor:

We read with interest the Anderson et al\textsuperscript{1} article entitled, “Risk of Pneumothorax Not Increased by Obstructive Lung Disease in Percutaneous Needle Biopsy,” which appeared in the June issue of Chest. We are pleased that the results confirmed our conclusions about this same procedure, which were previously published in Chest.\textsuperscript{2}

However, we were also somewhat surprised that the authors did not reference either our article since it had been published one month prior to Chest receiving the accepted revision by Anderson in November 1993 or our abstract\textsuperscript{3} that had been published in 1992.

We reported in Chest that our results from 145 fine-needle aspirations (FNA) suggested the development of a pneumothorax is not related to the presence of an obstructive or restrictive defect as measured by spirometry. Our conclusions now appear to be further supported by the results obtained by Anderson et al.

However, it remains still to be explained why the pneumothorax rate in our series was 20.2% (18/89) and for the Anderson et al group was 55.4% (33/60) even though the patients and the methodology were similar. The findings of both studies are in our opinion consistent with the hypothesis (proposed in our earlier manuscript) that post-FNA pneumothorax is related to a combination of technical and possibly operator-related factors, e.g., the size and number of bullae along the tract of the aspiration needle or the number of actual needle “passes.” Further supporting this hypothesis is the pneumothorax rate of 14% (21/145) for our total FNA group, i.e., those with and without spirometry. This rate is the lowest that we could find in our search of the literature, which also now includes the recent Anderson et al article.

We remain convinced that in this clinical setting the development of a pneumothorax, post-fine-needle aspiration of a lung lesion, is related to a combination of technical and operator-related factors that are yet to be definitively established.

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REFERENCES
1 Anderson CL, Acevedo Crespo JC, Lie TH. Risk of pneumothorax not increased by obstructive lung disease in percutaneous needle biopsy. Chest 1994; 105:1705-08
2 Hill PC, Spagnolo SV, Hockstein MJ. Pneumothorax with fine-needle aspiration of thoracic lesions: is spirometry a predictor? Chest 1993; 104:1017-1020

To the Editor:

We appreciate the comments by Dr. Spagnolo and his colleagues concerning our article, “Risk of Pneumothorax Not Increased by Obstructive Lung Disease in Percutaneous Needle Biopsy.” When a concept is widely accepted and quoted in many reviews, it usually takes more than one investigation to refute this concept. An increased risk of pneumothorax with obstructive impairment was supported by one clinical study with spirometry, which showed a fourfold increase in 159 patients.\textsuperscript{1,2} Now two independent studies with pulmonary function data, our study with 95 patients and yours with 89 do not show an increased risk of pneumothorax with obstructive impairment as defined by spirometry. Your study was not referenced in our article as we did not