public discussion regarding an issue that has long ago been considered “dead and buried” by many. While the issue of lung cancer screening has enormous public health implications, a recent broad-based American Cancer Society-sponsored National Conference on Cancer Prevention and Early Detection did not even address this issue. We have carefully avoided making any recommendations regarding public policy on lung cancer screening. Rather, we simply recommend a “consensus conference in order to formulate specific guidelines” (CHEST 1995; 107:270S-79S). We would encourage Parkin and Pisani, Reich, and Weiss to participate in such a forum in order to help resolve these complex and important public health issues.

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References


Is a Pulmonary Sequestration Supplied by the Coronary Artery?

To the Editor:

I read with interest the case report “Pulmonary Sequestration Receiving Arterial Supply From the Left Circumflex Coronary Artery” by Silverman and colleagues (CHEST 1994; 106:948-49). The authors claim that this is the first case of a pulmonary sequestration receiving arterial supply from the coronary artery. I am not quite sure if this case falls under the category of pulmonary sequestration. To me, this case represents an acquired inflammatory process with a communication between the coronary artery and the bronchial and pulmonary arteries. The patients had an episode of severe pneumonia at 9 years of age, and the CT shows a cystic lesion together with marked volume loss of the left lung. I would diagnose this case as a destroyed lung with cyst formation of the left lower lobe, resulting from pneumonia. The coronary artery can easily communicate with the pulmonary artery via the bronchial artery in acquired inflammatory or vascular diseases of the lung.1

I admit that pulmonary sequestration has a wide spectrum, and the intrapulmonary sequestration may be acquired in origin.2 I believe that this case, however, should not be called pulmonary sequestration. Further study is needed concerning the definition, cause, and classification of pulmonary sequestration.

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Vocal Cord Dysfunction Syndrome and “Steroid-Dependent” Asthmatics

To the Editor:

I would like to compliment Dr. Richard Moss on his recent review (CHEST 1995; 107:517-26) of steroid sparing agents in the treatment of severe or “steroid-dependent” asthma. It was a thorough review and will provide excellent guidance to the appropriate use of these agents. I think it, however, is important to stress that the diagnosis of steroid-dependent asthma must be made with absolute certainty before the use of these agents. It is becoming apparent that vocal cord dysfunction syndrome (VCDS) mimics severe or steroid-dependent asthma. We are currently studying over 100 patients with VCDS at The Ohio State University Medical Center. A portion of those patients arrived at our comprehensive asthma clinic with refractory or steroid-dependent asthma. A majority of those patients had VCDS, and if they were compliant with voice and speech therapy, they were able to wean off their corticosteroid therapy. This prevented further steroid-related complications and allowed patients to avoid alternate pharmacologic agents. Some patients have both mild asthma and VCDS with VCDS substantially contributing to the refractory nature of their respiratory problem.

Other diseases that can cause a worsening of asthma-like symptoms include chronic sinusitis and gastroesophageal reflux disease (GERD). Often these disorders can be “silent” and difficult to diagnose. These diagnoses need to be considered in all adult patients with refractory or steroid-dependent asthma, especially if they have other features of VCDS.1 GERD, or chronic sinusitis. Considerable morbidity can be avoided with appropriate diagnosis and therapy of these disorders. Corticosteroids may be weaned or even discontinued, and other potentially toxic agents may be avoided in these patients. We urge all clinicians to evaluate patients for VCDS, GERD, and chronic sinusitis before the initiation of steroid sparing agents for presumed severe asthma.

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Reference


To the Editor:

Although my review article (CHEST 1995; 107:517-26) was predicated on the assumption that the diagnosis of asthma is correct in such cases, I fully agree with Drs. Pacht and St. John that