public discussion regarding an issue that has long ago been consid-
ered “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 Con-
fERENCE on Cancer Prevention and Early Detection did not even
address this issue. We have carefully avoided making any recom-
endations 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 impor-
tant public health issues.

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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 Ar-
tery” 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 to-
gether 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 be-
lieve 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 re-
view (CHEST 1995; 107:817-26) of steroid sparing agents in the
treatment of severe or “steroid-dependent” asthma. It was a tho-
rough review and will provide excellent guidance to the appropriate
use of those agents. I think it, however, is important to stress that
the diagnosis of steroid-dependent asthma must be made with ab-
solute certainty before the use of those agents. It is becoming ap-
parent 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 ma-
jority of those patients had VCDS, and if they were compliant with
voice and speech therapy, they were able to wean off their cortico-
steroid therapy. This prevented further steroid-related complica-
tions and allowed patients to avoid alternate pharmacologic agents.
Some patients have both mild asthma and VCDS with VCDS sub-
stantially contributing to the refractory nature of their respiratory
problem.

Other diseases that can cause a worsening of asthma-like symp-
toms include chronic sinusitis and gastroesophageal reflux disease
(GERD). Often these disorders can be “silent” and difficult to di-
agnose. 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 discontin-
ued, and other potentially toxic agents may be avoided in these pa-
tients. We urge all clinicians to evaluate patients for VCDS, GERD,
and chronic sinusitis before the initiation of steroid sparing agents
for presumed severe asthma.

Eric R. Pacht, MD, FCCP, and
Roy C. St. John, MD, FCCP,
The Ohio State University Medical Center,
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1 Newman KB, Dubester SN. Vocal cord dysfunction: masquer-
der of asthma. Semin Respir Crit Care Med 1994; 15:161-67

To the Editor:

Although my review article (CHEST 1995; 107:817-26) was
predicated on the assumption that the diagnosis of asthma is cor-
rect in such cases, I fully agree with Drs. Pacht and St. John that

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