hyperlujnation associated with the obstruction, which is the functional condition of the risk of pneumothorax. Simple spirometry without determining lung volume does not allow this group at higher risk to be identified. This could be the cause of the difference in results from the various authors who did not take residual volume into consideration.

In particular, in the study by García-Río et al, the FEV1 values of the population with the pneumothorax were particularly low (56±10%), which implies a greater association with hyperinflation. Unfortunately, the incidence of patients with a pathologic FEV1 (<70%) was not given (it was 19% in our population). The different results in predictivity of FEV1 seem to be conflicting; but without the calculation of residual volume, it is not possible to know whether the patients with altered FEV1 and pneumothorax also had significant alveolar hyperinflation. With regard to the conclusion of our study, we do not disagree with García-Río et al, but we state again that spirometric examination with the determination of static and dynamic lung volumes is useful prior to PNB.2

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References

Sedation in Fiberoptic Bronchoscopy

To the Editor:

We read with interest the recent study by Malais and colleagues1 concerning the use of oral lorazepam as sedation for fiberoptic bronchoscopy. We were disappointed that the authors did not take note of a recently published study comparing IV midazolam versus IV phenoperidine/droperidol combination vs placebo in patients undergoing diagnostic fiberoptic bronchoscopy but not diagnostic lavage.2 In this study, opiate sedation conferred no advantage over placebo in patient perception of comfort, but reduced willingness to have a repeat bronchoscopy, a finding attributed to the dysphoric effects of the opiate. The midazolam regimen, although making the procedure easier for the bronchoscopist (as determined by visual analogue scale) was not significantly better than the placebo sedation for patient comfort or willingness to have the procedure repeated.

The study by Malais and colleagues1 is important in highlighting that an oral premedication, with its ease of administration and no requirement for venous access, is a useful alternative. However, some caution must be urged as patients receiving minor tranquilizers are known to be at an increased risk of automobile accidents.3 Benzodiazepines, particularly in the elderly, have also been shown to decrease daytime performance4 and increase the risks of hip fracture.5

If sedation is to be used during bronchoscopy, parenteral administration of short-acting benzodiazepine makes the procedure easier for the doctor while allowing the depth of sedation to be controlled and providing venous access.6 Although such issues are important, one must not lose sight that the patient should be involved in whether they wish to have sedation, especially as it confers little advantage over placebo. From personal experience we find that many patients prefer to have no sedation and be allowed to drive home after the procedure.

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Advanced Pulmonary Histiocytosis X Is Associated With Severe Pulmonary Hypertension

To the Editor:

Histiocytosis X (HX) is a rare disease that can involve destruction of the lung parenchyma, due to the proliferation of Langerhans' cells in the airway spaces. Lesions present an almost entirely peribronchial distribution, and therefore, the disease could be considered a bronchiolitis.

On the basis of radiologic CT findings of increased size of the pulmonary arteries, some reports have suggested the presence of pulmonary hypertension (PH) (Fig 1).1,2 In 1990, Cunningham and Parkincons6 described the obstruction of vascular lumina due to the proliferation of Langerhans' cells in some cases of lung HX with PH. This observation, however, has never been confirmed by extensive hemodynamic studies, to our knowledge.

From 1986 to December 1995, 21 patients with advanced pulmonary involvement due to HX were addressed to our institutions for lung or heart and lung transplantation. A histologic diagnosis was available in 15 cases, while in two patients, radiologic features consistent with the presence of bone eosinophilic granuloma were present. In two more patients, an elevation of CD1a-positive cells (more than 5%) on bronchoalveolar lavage strongly supported this diagnosis, while in the remaining two patients, a clinico-radiologic diagnosis was accepted. Pulmonary function tests (PFTs) and hemodynamic data are reported in Table 1.

Twenty of 21 patients presented a certain degree of PH, 12 a severe degree (mean pulmonary artery pressure >50 mm Hg). The level of PH was not related to the impairment of PFTs, in particular to hypoxia. Actuarial survival at 50 months was 58% and none of the PFT or hemodynamic data resulted in prognostic factors. Moreover, a similar degree of PH was not observed in patients with lymphangioleiomyomatosis (n = 8) or pulmonary fibrosis (n = 43) evaluated for lung transplantation.