ogy, including frequency of cough, sputum production, wheeze, and breathlessness. The “activity” component has to do with physical activities that either cause or are limited by breathlessness. The “impact” component covers such factors as employment, being in control of one’s health, panic, need for medication, side effects, and disturbances in daily life. Since the SGRQ does not conclude a psychological dimension, the “well-being” component of the Medical Psychological Questionnaire for Lung Diseases (MFQQL) was added to the SGRQ. Well-being mainly measures the state of mind, including anxiety.

In conclusion, we do not agree with the authors of the previous letter. In our study, HRQL refers to the subjective experience of the impact of the disease on daily functioning, measured by a standardized instrument.

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REFERENCE


Exercise Testing in Patients With Interstitial Lung Disease

To the Editor:

We commend Erbes and colleagues (January 1997) for investigating the value of lung function tests in predicting prognosis of patients with interstitial lung disease (ILD), but are concerned that data available to them were not considered and that comments in the accompanying editorial2 “Simple may be better” could be misinterpreted. First, the emphasis on total lung capacity (TLC) and vital capacity rather than other physiologic measures may be unwise. The normal mean FVC and low mean FEV1/VC found in their smoking subjects (over half of their sample) are not physiologically characteristic of the usual idiopathic pulmonary fibrosis and suggests that their patients might have a different disorder. Second, as prognostic factors, they failed to present important and relevant data available to them, such as VO2max/VO2 predicted and exercise physiologic dead space ventilation (Vd/VT), which characterize the maximum ability to perfuse the lung and gas exchange efficiency, respectively. Also, they emphasized gas transfer per alveolar volume (DCO/VA’), rather than total gas transfer (DCO), even though DCO is a better indicator of overall disease severity than DCO/VA’. Exercise limitation in patients with ILD is better predicted by measures of DCO than by FEV1 or TLC.3 Our recent study of patients with ILD found that limitation of the pulmonary circulation to increase appropriately is usually more important than the more simply measured abnormalities of lung mechanics. Others1,3,5 have emphasized the importance of pulmonary vascular disease and secondary pulmonary hypertension in these patients. Recent advances in the treatment of primary pulmonary hypertension give hope that secondary pulmonary vascular disease due to fibrosing diseases of the lung may also be treatable. Most importantly, in the individual patient, gas transfer and cardiopulmonary exercise tests can help (1) evaluate whether circulatory, ventilatory, or gas exchange factors dominate; (2) indicate where therapy should be targeted; and (3) assess the effectiveness of such therapy.

Eliminating measurement of arterial blood gas, DCO, and cardiopulmonary exercise testing in ILD patients might rarely reduce costs ($497 per patient in one institution as noted in the accompanying editorial2). However, the pathophysiology is not the same in all patients with ILD. An abbreviated assessment of the mechanism of activity limitation is unlikely to be in the patient’s best interest and might not save money in the long run. The danger is that the findings of Erbes et al1 might be read uncritically and be taken out of context by those eager to minimize patient care costs. Simple may not be better.

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REFERENCES

2 Kirtland SH, Winterbauer RH. Pulmonary function tests and idiopathic pulmonary fibrosis. Simple may be better. Chest 1997; 111:7-8

To the Editor:

We appreciate the comments by Hansen and Wasserman on the work of Erbes et al1 and our accompanying editorial.2 We will leave to Erbes and colleagues to answer the issues raised regarding the specifics of their study.

Exercise testing in interstitial lung disease (ILD) remains an area for clinical investigation. Studies defining exercise pathophysiology, mechanisms of exercise limitation, cause of dyspnea, etc, offer potential for patient management. At present, however, we find no reported clinical experience that convincingly ties measures of exercise physiology to clinical decision making. Hansen and Wasserman note that “the pathophysiology is not the same in all patients with ILD” and base their claim of importance of exercise studies on a retrospective review of 42 patients studied on a single occasion.3 Nine patients were diagnosed with idiopathic pneumonolgy fibrosis (IPF), only five of whom had a lung biopsy. It’s not stated whether this is a surgical biopsy or transbronchial biopsy. The other 33 patients suffered from an assortment of illnesses, including collagen vascular-associated ILD, sarcoidosis, pulmonary alveolar proteinosis, asbestiosis, and pulmonary fibrosis. Their finding of exercise limitation defined by abnormalities of pulmonary circulation is provocative, but its importance is in stimulating further investigation and not as a mandate for the addition of exercise testing to current practice. We continue to recommend a directed assessment for management of the patient with IPF, which includes the measurement of total lung capacity, vital capacity, and diffusion of single breath at baseline and at serial follow-ups for information regarding prognosis and the course of the disease. We utilize gas