these comments are helpful in encouraging more surgeons to apply and report their experiences with octreotide.

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REFERENCE


Endobronchial Sarcoidosis and Hyperreactive Airways Disease

To the Editor:

We read with interest the article by Shorr et al (September 2001),1 regarding the hyperreactive airway response (AHR) seen in the subgroup of nonsmoking patients with newly diagnosed sarcoidosis and endobronchial disease. Although the data are limited,1 (Table 1) if sarcoidosis is a given, the probability of the test (endobronchial biopsy) for diagnosing sarcoidosis approaches one if the patient has AHR with no other obvious etiology for AHR. In nonsmoking subjects who present with abnormal chest radiographic findings compatible with stage I sarcoidosis, the probability of getting an endobronchial biopsy compatible with sarcoidosis is about 50% if the patient eventually is found to have sarcoidosis.2 Presumably, if the patients in that study also had AHR, the probability of making a diagnosis of sarcoidosis would increase even further, and the best way to do it might be by endobronchial biopsy if there are no external lesions to sample and the Kveim test was not available.3,4 If more data back up the claim that AHR in newly diagnosed sarcoidosis almost always guarantees a diagnosis of endobronchial sarcoid, then AHR can be added to the diagnostic approach in making a diagnosis of lung disease in subjects with nondiagnostic symptoms and other indicators suggestive of sarcoidosis.

In patients without a diagnosis with chest radiographic findings compatible with stage I sarcoidosis and AHR with no other cause, the leading diagnosis should probably be sarcoidosis until proven otherwise,3 assuming this preliminary study is correct. In this particular case scenario, the endobronchial biopsy would be of great value. We look forward to more studies validating the findings of Shorr et al.1

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To the Editor:

We appreciate the comments of Pesola and colleagues regarding our study of airway hyperreactivity (AHR) in patients with sarcoidosis.1 In order to determine if endobronchial biopsy (EBB) should be performed during bronchoscopy for suspected sarcoidosis, they suggest that clinicians rely on the results of formal AHR testing. If AHR is present, they imply, then EBB would be useful. However, if AHR is absent, then EBB should be avoided. We disagree. First, the yield of EBB is high, irrespective of the presence or absence of AHR. As we showed in an earlier analysis2 of a diverse cohort of patients, EBB findings are positive in >60% of subjects. More importantly, the addition of EBB to transbronchial biopsy increases the diagnostic yield of bronchoscopy by 20%. Second, EBB is safe and minimally increases the length of the procedure. This point is particularly important, since a more invasive and costly intervention such as mediastinoscopy might be required if a bronchoscopy is nondiagnostic. In short, the risk-benefit ratio associated with EBB favors employing this technique routinely in cases of suspected sarcoidosis.

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The opinions expressed herein are not to be construed as official or as reflecting the policy of either the Department of the Army or the Department of Defense.

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Preoperative Bronchoscopic Biopsies and Staging

To the Editor:

We read with interest the article by Riedel et al (June 2001),1 who concluded that systematic multiple biopsies and brush and washing cytology are an accurate procedure in evaluating possible airway invasion by supraglottic epiglottal carcinoma. We also use biopsies in our practice,2 but we are very cautious in the interpretation because we have had a lot of negative biopsy findings in patients in whom tracheobronchial invasion was evident at bronchoscopic examination. Therefore, we do not feel confident in making a clinical choice (airway infiltrated or not, that is, operate on the patient or not) based on the results of the biopsies.

Looking in depth at the data of Riedel et al,1 (Table 2) there was
1 negative biopsy finding among 5 adequate biopsies on 5 patients with an endoluminal mass, 3 negative biopsy findings among 8 adequate biopsies on 8 patients with frank mucosal infiltration, 1 negative (it was adequate) biopsy finding in a patient with malignant tracheoesophageal fistula, and 8 negative biopsy findings among 13 adequate biopsies on 13 patients with a rigid protrusion. Even more striking are the results of biopsies after CRT. From these data, it is evident that there are a lot of negative biopsy findings also if taken from pathologic tissue (frank mucosal infiltration, tracheoesophageal fistulas, endoluminal mass), and that, also in the experience of Riedel et al, are not very reliable. Similar results are reported with brush cytology and washing cytology. Certainly, if biopsy findings are positive, the airway invasion is sure and a radical resection is impossible. However, Reidel et al (Table 5) reported a patient with a “microscopic proof of cancer at bronchoscopy” (that is, we suppose, positive biopsy or brushing findings) and “no airway invasion at surgery.” This is really surprising and shows that biopsies are not reliable.

In conclusion, we think that it is wrong to make any preoperative judgment about radical resectability based on the results of biopsies. These can be useful if considered in an integrated fashion with bronchoscopic findings (distinguishing mobile from rigid protrusion), CT scan, etc.

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To the Editor:

Drs. Baisi and Bonavina, in their comments about our article on bronchoscopic staging of esophageal cancer, suggest that it is wrong to make any judgment about radical resectability based on results of biopsies. They cite our findings of some negative biopsies taken from macroscopically abnormal tissue; however, they fail to realize that our decision about resectability was based on a combination of macroscopic findings, biopsies, and brush and washing cytology. With this combined mode of evaluation, the specificity and accuracy was statistically significantly better than it would be if we were to rely on the subjective interpretation of macroscopic findings only. In our series, 18 patients with macroscopic abnormalities, but without microscopic proof of cancer, eventually underwent an R0 resection; they would have been rejected for curative surgery if the diagnosis of airway invasion had been based on macroscopic findings only.

The interpretation of bronchoscopy in the assessment of airway invasion of esophageal cancer after radiochemotherapy is, without doubt, more difficult than at baseline staging; the positive predictive value of macroscopic abnormalities without microscopic proof of cancer is low. This underlines the importance of biopsies rather than questions their value.

The one patient reported (Table 5) with “microscopic proof of cancer at bronchoscopy” and no airway invasion at surgery had normal results of macroscopic examination, negative biopsies, and negative washing cytology; only the results of brush cytology were evaluated as “strongly suspicious of cancer,” as clearly stated in the text of our article. The final decision to operate on this patient was made by the surgeons and was clearly the correct decision. This case certainly does not support the conclusion of Drs. Baisi and Bonavina that biopsies are not reliable.

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REFERENCES


Outpatient Pulmonary Rehabilitation

To the Editor:

We read with great interest the article by Finnerty et al (June 2001). This large, randomized, controlled trial showed that, in patients with COPD, outpatient rehabilitation can improve walking distance and health-related quality of life for 12 weeks. These results were obtained in a nonteaching hospital, so the authors suggested that the results of previous studies could now be extrapolated beyond centers dedicated to these regimens. Still, several earlier studies have shown comparable positive results even after rehabilitation in the home setting. In the present paper, the studies by Wijkstra et al and Cambach et al were both cited as outpatient rehabilitation programs. However, the patients in these studies received their training from a local physical therapist in the community and were not supervised by hospital staff. Studies with a comparable design, like Strijbos et al and Hernandez et al also showed that rehabilitation programs carried out in a home setting were beneficial. Thus, rehabilitation programs can be very effective in specific groups of patients with COPD in different settings. If these patients receive adequate training, it can be beneficial not only in an outpatient setting beyond a teaching hospital but even in a setting in the community, with no direct supervision from the hospital.

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