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 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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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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Spiral CT Is Not the Final Answer

To the Editor:

We enjoyed reading the article by Paterson and Schwartzman in CHEST (June 2001), concluding that "spiral CT can replace pulmonary angiography in patients with nondiagnostic V/Q [ventilation/perfusion] scans." We wish to raise several issues regarding these recommendations.

This conclusion is based solely on a hypothetical model that does not represent actual clinical practice and decision making. We think that adopting their diagnostic approach may not be sufficient to exclude clinically significant pulmonary embolism. Furthermore, this could potentially lead to unnecessary treatment or lack of appropriate anticoagulation.

First, there are known issues surrounding subsegmental pulmonary emboli. It is known that the sensitivity of spiral CT in this area is not high. Relying on spiral CT in these situations may result in missing small peripheral clots and their potential impact on patients with limited cardiopulmonary reserve.

Second, the differences among radiologists in interpreting helical CT, especially in centers with less experience, are considerable. This fact was not discussed in this article or taken into account in their model.

Several investigators have studied the role of the d-dimer test in the workup of pulmonary embolism. We are glad that the authors referred to d-dimer in their discussion. Dabbagh et al studied the correlation between spiral CT of the chest and d-dimer latex agglutination test (Accuclot; Sigma Diagnostics; St. Louis, MO) among 79 patients (77% women). They found that a negative d-dimer result (<0.25 mg/mL) highly predicted a negative spiral CT of the chest result (negative predictive value, 100%). We believe that spiral CT scan of the chest might not be necessary in the presence of a negative d-dimer test result by latex agglutination.

Although we believe that spiral CT of the chest can be very helpful in the evaluation of pulmonary embolism, we do not think it is the complete and final answer.

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Salmeterol Powder Provides Significantly Better Benefit Than Montelukast in Asthmatic Patients Receiving Concomitant Inhaled Corticosteroid Therapy

To the Editor:

I have read with interest the study by Fish et al (August 2001).1 In this study, salmeterol added to inhaled corticosteroids was statistically superior to adding montelukast to inhaled corticosteroids in improving a number of traditional outcome variables such as morning and evening peak expiratory flow (PEF), percent of symptom-free days, percent of rescue-free days, supplemental albuterol use, nighttime awakenings, and some subjective symptoms. Reported daytime wheezing was not different. I am afraid that the design of this study favored this outcome as one of the inclusion criteria was an improvement in FEV1 of at least 12% to 114% after treatment with beta2-agonists. Therefore, the observed results are not surprising, because an improvement of >12% in FEV1 after treatment with beta2-agonist was predetermined by these entry criteria. On the contrary, it is noteworthy that montelukast also improved the primary efficacy measure, which was PEF. While the authors claim that the sample size per treatment arm provided >90% power to detect a significant difference of 15 L/min from baseline in the morning PEF, the mean difference between the two treatments observed was only 13.3 L/min. I question the scientific interpretation as well as the clinical significance of their observation. Furthermore, in my view, statistically significant differences such as a reduction of ~0.1 nighttime awakenings per week are hardly clinically relevant. Again, I question whether, indeed, salmeterol powder provides better benefit than monte-

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