To the Editor:

I agree that two of the studies cited in our paper as outpatient-based were, in fact, not supervised by hospital staff but were entirely community-based. I am entirely in agreement that rehabilitation programs can be very effective in the community, and indeed, while the professional input remains similar to before, our current pulmonary rehabilitation program is conducted entirely in the community, in co-operation with general practitioners.

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REFERENCES


Spiral CT Is Not the Final Answer

To the Editor:

We enjoyed reading the article by Paterson and Schwartzman (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 al3 studied the correlation between spiral CT of the chest and d-dimer latex agglutination test (Acceclor; Sigma Diagnostics; St. Louis, MO) among 79 patients (77% women). They found that a negative d-dimer result (<0.25 mg/L) 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).4 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 13.3 L/min. I question the primary efficacy measure, which was PEF. While the authors claim that the sample size per treatment arm provided 80% 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-
Environmental Tobacco Smoke Exposure and Adult Asthma

To the Editor:

Larsson and colleagues (September 2001) examined the relation between childhood environmental tobacco smoke (ETS) exposure and the prevalence of self-reported asthma in adulthood. As the authors point out, the effect of ETS exposure on childhood asthma induction is not in doubt. Based on > 40 epidemiologic studies, extensive data support a causal association between ETS exposure and induction of asthma in children. However, the relationship between ETS exposure and adult-onset asthma has received less attention.

The study of Larsson et al contributes to the literature linking ETS exposure with a greater risk of asthma. Unfortunately, the study does not clearly advance our understanding of how childhood ETS exposure affects the onset of asthma during adulthood. The study presents two alternate definitions of asthma, both of which measure lifetime prevalence of asthma. In other words, the prevalence of ever having asthma or having a physician diagnosis of asthma could reflect onset of asthma during childhood or adulthood. Without knowing the age of asthma onset, the observed association between childhood ETS exposure and adult asthma prevalence could be explained by the well-known relation between ETS exposure and childhood asthma.

Based on the available epidemiologic literature and strong biologic plausibility, ETS exposure is a likely cause of adult-onset asthma. To better define this relationship, future studies should evaluate incident, rather than prevalent, adult asthma cases.

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REFERENCES

Workup Following Tissue Expectoration

To the Editor:

The article by Kelly et al (February 1999) was of interest to us. The most common causes of expectoration are a result of infection with secondary bronchitis or pneumonia and tumor presence. Microscopic presence of carcinoma cells in sputum is common. It is uncommon, however, to see large portions of the tumor expectorated. Kelly et al have reviewed the literature and discussed expectoration of endobronchial tumors. This subject has been of interest to us over the years as evidenced by our article.

The patient mentioned in our article had a large poorly differentiated squamous cell carcinoma tumor cast of the bronchus expectorated. Kelly et al have reviewed the literature and discussed expectoration of endobronchial tumors. The patient described in our article has a large poorly differentiated squamous cell carcinoma tumor cast of the bronchus expectorated postbronchoscopy. Since the time of that article in 1974, we have noted a number of patients with both primary and metastatic endobronchial lesions, who have expectorated bronchial casts or portions of the tumor, which on presentation to the laboratory for microscopic examination demonstrated the underlying etiology. We have found that most patients with significant hemoptysis, however, did not notice the presence of a tumor cast or mass; therefore, if such a specimen was present, it was not salvaged. We endorse further evaluation, endoscopic examinations, and radiographic review of any patient reporting expectoration of firm or hard tissue-like masses, even if the specimen has not been salvaged for gross or microscopic examination. A high index of suspicion will usually lead to definition of the underlying etiology even when radiographic findings appear normal.

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