Therefore, given the evaluation biases and the complication rate of this invasive procedure, we remain unconvinced that airway stenting provided any real clinical benefit to this group of patients. Until more solid data emerge (we certainly support the prospective series and databases that Ernst and colleagues suggest), we contend that objective documentation of airflow limitation in central airways should be part of the definition of “severe tracheobronchomalacia.” Otherwise, we take the risk of treating images, not diseases.

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REFERENCE


Reference Values for Exhaled Nitric Oxide in the General Population

To the Editor:

We read with interest the article by Olin et al1 on the influence of age and height on fractional exhaled nitric oxide (FENO) in a sample of lifelong never-smoking adults randomly selected by a postal questionnaire from the general population. According to these authors,2 the upper limits of FENO range from 24.0 to 54.0 parts per billion (ppb), and the geometric mean of FENO for the whole population is 16.6 ppb (95% confidence interval [CI], 5.87 to 47.14 ppb). Age and height would account for 9 to 11% of the variance of reference values. We think that these statements deserve a comment: in fact, such upper FENO values are definitely higher than those reported in healthy subjects, in both adults and children in American Thoracic Society/European Respiratory Society guidelines3 and in our experience. The “normal” range for FENO is influenced by constitutional as much as by environmental and pathophysiologic factors.2 We do agree that only studies in the general population could detect associations between “abnormal” FENO values and known and supposed risk factors. Recently, Rolla et al.,4 investigating 108 of 590 consecutive patients referred in 1 year for rhinitis, reported that FENO is significantly higher in patients with allergic rhinitis and chronic rhinosinusitis compared to patients with nonallergic rhinitis (44.3 ppb [95% CI, 34 to 54 ppb] and 53 ppb [95% CI, 42 to 64 ppb] vs 22 ppb [95% CI, 18 to 27 ppb], respectively), reinforcing and extending the Allergic Rhinitis and Its Impact on Asthma guidelines5 of testing for asthma patients with allergic rhinitis. Seasonal variations of FENO values due to fluctuations of exposure to allergens have also been reported in patients with allergic asthma and also seasonal allergic rhinitis. According to this hypothesis, whether the measurements were performed during or outside the pollen season should have been reported, with rhinitis and asthma having a similar weight in FENO changes as recently reported by Travers et al in a random community survey of adults. The high prevalence of allergic rhinitis and/or nasal symptoms, probably missing in replies to the questionnaire, could represent an important confounder for reference values. Moreover, a positive correlation between FENO and dietary consumption of fats in children with asthma assuming low levels of antioxidants has recently been reported,9 thus suggesting the need of further studies might aimed at investigating the relationship between FENO levels and dietary habits. In conclusion, the evaluation of normal values for FENO in the general population must take in account not only smoke, gender, height, weight, age, atopy, current respiratory and nasal symptoms, asthma, and steroid assumption, but probably some other factors such as diet. Establishing reference values is particularly difficult when the prevalence of potential confounders and of the clinical condition to be diagnosed is relatively high in the general population. Unless a valid reason is provided to explain such high values, their use for diagnostic purposes is potentially misleading.

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Tregs on immunopathology in cancer patients. However, he did not discuss the effects of Tregs in patients with allergic diseases, and suggested that the induction of Treg development might be useful in this field. Indeed, Tregs play an essential role in immune homeostasis and protection against autoimmunity, but also exert a detrimental action in the generation of host-vs-tumor immunity via the suppression of tumor-specific effector T-cell responses and the development of immune tolerance to neoplastic cells. Animal models for cancer have shown that Treg depletion improves antitumor immunity and the success of immunotherapy; the hypothesis that a reduction of Treg function in cancer patients could be therapeutic is currently investigated. Therefore, the therapeutic manipulation of Tregs should always consider the double-edged sword of this action.

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Errata

In the January 2008 issue, in the editorial by Irwin and Welch, “Becoming the Journal of the Future” (Chest 2008; 133:1–3), on page 2, the sentence beginning on line 3 of the first column contained errors. It should read: “In the spirit of improving the accuracy of reporting results, we will be requiring that all new submissions of the following types of studies, beginning February 4, 2008, follow the standardized requirements of reporting that can be found in the Uniform Requirements and our Instructions to Authors: randomized controlled trials must follow the Consolidated Standards of Reporting Trials (CONSORT) requirements; studies of diagnostic accuracy, the Standards for Reporting of Diagnostic Accuracy (STARD) requirements; meta-analyses and systematic reviews, the Quality of Reporting of Meta-Analyses (QUOROM) requirements; observational studies in epidemiology, the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) requirements; and meta-analyses of observational studies in epidemiology, the Meta-Analyses of Observational Studies in Epidemiology (MOOSE) requirements.”

In the January 2008 issue, in the article by Swigiris et al, “Pulmonary and Thrombotic Manifestations of Systemic Lupus Erythematosus” (Chest 2008; 133:271–280), the third author’s name was misspelled. It is Joann Gillis.

In the January 2008 issue, in acknowledgement of reviewers, “CHEST Reviewers 2007” (Chest 133:322–332), two names were inadvertently omitted: they are Ephraim Bar-Yishay, PhD, and Scott Woller, MD.

An erratum published in the February issue (Chest 2008; 133:588) did not contain the information to complete the correction. The erratum should have read as follows: In the Meeting Abstracts supplement to the October 2007 issue, in the Abstract by Rachel A. Heft “Electroophoreric Respiration (EPR)” in Chronic Respiratory Failure” (Chest 2007; 132(suppl):574S), the authorship is displayed incorrectly. It should read Rachel Heft BSc, RRT, MEd, West Park Health Care Center, Toronto, Ontario; Roger Goldstein, MB ChB, West Park Health Care Center, Toronto, Ontario; Amir Ariel West Park Health Care Center, Toronto, Ontario; Ken Aron Avery Biomedical Devices, Inc.

Regulatory T Cells, Allergic Diseases, and Cancer

To the Editor:

Larché in his excellent review in a recent issue of CHEST (September 2007) highlighted the potential defective function of regulatory T cells (Tregs) in patients with allergic diseases, and suggested that the induction of Treg development might be useful in this field. However, he did not discuss the effects of Tregs on immunopathology in cancer patients.

Tregs play an essential role in immune homeostasis and protection against autoimmunity, but also exert a detrimental action in the generation of host-vs-tumor immunity via the suppression of tumor-specific effector T-cell responses and the development of immune tolerance to neoplastic cells. Indeed, many of the mechanisms that impede antitumor immunity result in the development of Tregs. Animal models for cancer have shown that Treg depletion improves antitumor immunity and the success of immunotherapy; the hypothesis that a reduction of Treg function in cancer patients could be therapeutic is currently investigated.

In the spirit of improving the accuracy of reporting results, we will be requiring that all new submissions of the following types of studies, beginning February 4, 2008, follow the standardized requirements of reporting that can be found in the Uniform Requirements and our Instructions to Authors: randomized controlled trials must follow the Consolidated Standards of Reporting Trials (CONSORT) requirements; studies of diagnostic accuracy, the Standards for Reporting of Diagnostic Accuracy (STARD) requirements; meta-analyses and systematic reviews, the Quality of Reporting of Meta-Analyses (QUOROM) requirements; observational studies in epidemiology, the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) requirements; and meta-analyses of observational studies in epidemiology, the Meta-Analyses of Observational Studies in Epidemiology (MOOSE) requirements.”

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