on the sensitivity and specificity of the test employed, but also on the prevalence of the disease (pretest probability) in the study population. Current data report the presence of Ex-PHtn in COPD, heart transplantation, susceptibility to high-altitude pulmonary edema, congenital heart disease, thromboembolic pulmonary hypertension, scleroderma, and relatives of patients with pulmonary arterial hypertension. However, the actual prevalence and clinical value (early stage disease?) of Ex-PHtn in the wide spectrum of conditions involving the cardiorespiratory system remain not fully explored.1–4,6–11

4. Well-designed longitudinal studies are warranted to investigate the natural history of pulmonary hypertension and whether preclinical treatment can prevent the development of more severe forms of pulmonary vascular disease in susceptible persons. Ex-PHtn remains a fascinating clinical condition and further echo a versatile tool “to look beyond the scene” of otherwise unexplained effort dyspnea.

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Oral vs IV Corticosteroids for In-Hospital Treatment of COPD Exacerbations

To the Editor:

In the December 2007 issue of CHEST, de Jong, et al1 compared the use of oral and IV prednisolone in the treatment of inpatients with COPD exacerbations. In an accompanying editorial, Taskin2 emphasized that the treatment failure rate at 90 days in both treatment groups was quite high (IV prednisolone group, 67%; oral prednisolone group, 56.3%). In an earlier study, Niewoehner et al3 had a much lower failure rate at a similar interval (37%) using a much higher prednisolone dose for a slightly longer interval. Taskin2 rightly encouraged carefully designed trials to address the impact of different dosing regimes of systemic corticosteroids in hospitalized patients with acute exacerbations of COPD.

I would make a plea to compare the use of a single daily dose of the corticosteroid (as in the study by de Jong et al1) with comparable total but divided daily-dose regimens of prednisolone. These studies would be useful in both inpatient and outpatient settings and for patients with exacerbations of COPD, bronchial asthma, and other allergic illness. It is my firm clinical impression (albeit anecdotal) that divided dose administration of prednisolone is more effective and has a longer duration of action than single daily-dose administration. I am aware of the theoretical concern about more adrenal-pituitary axis disruption with the divided dose (and therefore more therapeutic effect), but because of the relatively short duration of these dosing schedules (ie, < 30 days), we do not see any adverse effects.

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