standard of elevated pulmonary pressures, some patients might not even technically meet the criteria for pulmonary hypertension.

- The authors fail to definitively demonstrate the type of pulmonary hypertension. Although they report that pulmonary hypertension was due to idiopathic pulmonary fibrosis, which would generally place the patients into class 3, the readers are forced to assume this information.
- There is possible misclassification of pulmonary hypertension. In an elegant study, Halpern and Taichman demonstrated that many patients with a diagnosis of pulmonary arterial hypertension were misclassified and should have been classified with pulmonary venous hypertension (about one-half the patients in their study were misclassified).
- There is no mention as to whether the patients were treated for pulmonary hypertension.
- There is no mention as to whether the patients had a history of controlled or uncontrolled hypertension. Pulmonary hypertension has many causes, and suboptimal control of hypertension can cause elevated pulmonary pressures (class 2 pulmonary hypertension).
- There were differences in pulmonary pressures during surgery. The patients did not necessarily have a preoperative placement of the pulmonary arterial catheter. Pulmonary pressures can vary with volume resuscitation, intubation, type of mechanical ventilation, sedation, and so forth. The authors do acknowledge this limitation but still go on to state definitively that the lack of these data did not confound the relationship of the mPAP with PGD.

A reproduction of this study, correcting for the above concerns, would add significant value to the current literature. This would then allow clinicians to accurately assess risk factors for PGD in this instance and to counsel patients on the potential complications.

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REFERENCES

Response
To the Editor:

We appreciate the interest of Drs Jenks and Uysal in our article. We agree that not all the subjects with primary graft dysfunction (PGD) had a mean pulmonary arterial pressure (mPAP) > 25 mm Hg and that not all the subjects without PGD had an mPAP < 25 mm Hg. It was precisely for this reason that we presented our finding of a higher mPAP in patients with PGD than in those without as a continuous variable. The study was limited to patients with idiopathic pulmonary fibrosis, but not all patients with higher mPAP met the World Health Organization criteria for pulmonary hypertension, leading us to avoid the application of potentially inaccurate phenotypes. We do not have records of whether the subjects were actively being treated for pulmonary hypertension with pharmacologic agents.

Further, we agree that many factors may influence the first recorded pulmonary arterial pressure during the transplant procedure in patients with idiopathic pulmonary fibrosis. In order for intravascular volume or mechanical ventilation to account for our findings, patients at greater underlying risk for PGD would have to have more intravascular volume administered and higher levels of ventilator support before the diagnosis of PGD is made. Although this is unlikely, we see this as an opportunity for future research.

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REFERENCES

Flavocoxid and Hypersensitivity Pneumonitis
To the Editor:

I have just become aware of the report in CHEST (October 2010) by Youssef and Tomic of a case of hypersensitivity pneumonitis...
associated with the use of our product, Limbrel (flavocoxid). I wish to thank them for their clear and concise description of the clinical presentation and appropriate treatment of this rare event.

Limbrel was first marketed nationally in April 2004. At that time, no instances of hypersensitivity pneumonitis had been reported in clinical trials or test marketing surveillance. By 2008, three cases had been reported, and the package insert was revised to reflect this complication. At the time of its most recent revision, in mid-2010, the package insert was again revised to reflect seven confirmed cases reported in post-marketing surveillance and through the US Food and Drug Administration’s MedWatch. As of that time, approximately 270,000 people had been exposed to the product as judged by the number of new prescriptions filled. Thus, the apparent incidence of hypersensitivity pneumonitis, as nearly as we can estimate it, is approximately 0.0023%, or somewhere around two to three per 100,000.

Given such a low incidence, it is unlikely that any individual physician would encounter the problem. The report by Youssef and Tomic should increase awareness of this rare event and enable more rapid institution of appropriate therapy and avoidance of unnecessary and inappropriate treatments.

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REFERENCES

Response

To the Editor:

We appreciate the comments from Dr Robert Levy about our case presentation. First, we would like to applaud the pharmaceutical company for their efforts in careful monitoring of published literature concerning their products. It is encouraging that their safety packets are regularly updated to reflect new reports of possible side effects.

Hypersensitivity pneumonitis represents a complex pulmonary disorder of varying intensity and clinical presentation, which is characterized by a diffuse Tc1 immune response of lung parenchyma in patients previously sensitized to one of >300 causative agents that may favor the hypersensitivity pneumonitis reaction. It remains an elusive diagnosis that is achieved by performing clinical, radiologic, physiologic, and immunologic evaluations. Hypersensitivity pneumonitis is known to be caused by a large number of different medications. This possible side effect can go unnoticed and misdiagnosed if physicians do not report their experiences. Possible consequences can include many unnecessary procedures that can cause an increase in morbidity and mortality for the patients.

The purpose of our case presentation was to bring to light a possible, though rare, side effect that patients may experience when their doctors administer flavocoxid (Limbrel). Increasing the awareness of yet another possible cause of hypersensitivity pneumonitis will help physicians to reach the right diagnosis and avoid unnecessary and potentially harmful diagnostic procedures.

Also, it will be useful to review all published reports of flavocoxid causing hypersensitivity pneumonitis in order to assess the common characteristics among these patients that could have predisposed them to hypersensitivity pneumonitis. This will help us to identify groups of patients who should avoid flavocoxid. We believe that our report will help physicians and increase the awareness of this rare but possible cause of hypersensitivity pneumonitis.

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Can Pulmonary Arterial Hypertension Be Diagnosed by an Elevated Pulmonary Capillary Wedge Pressure Outside of the Guideline Criteria?

To the Editor:

We read with interest the report by Frost and colleagues in a recent issue of CHEST (July 2011) comparing the results of the Registry to Evaluate Early and Long-term Pulmonary Arterial Hypertension Disease Management (REVEAL Registry) with the other registries of pulmonary arterial hypertension (PAH). We are troubled by the inclusion of patients with a pulmonary capillary wedge pressure (PCWP) > 15 mm Hg, a value > 2 SD higher than the 95% confidence interval of the Registry to Evaluate Early and Long-term Pulmonary Arterial Hypertension Disease Management (REVEAL Registry) with the other registries of pulmonary arterial hypertension (PAH). We are troubled by the inclusion of patients with a pulmonary capillary wedge pressure (PCWP) > 15 mm Hg, a value > 2 SD higher than the 95% confidence interval.