

Correspondence

Pulmonary vascular lesions in the toxic oil syndrome in Spain

SIR.—I read with great interest the article on the toxic oil syndrome in Spain by WP Fernández-Segoviano and others (October 1983; **38**: 724). Although the basic toxic agent found in the denatured rapeseed oil ingested by their patients might be oleanilid as they described, the possibility of poisoning by polychlorinated biphenyls (PCBs) should be taken into consideration. PCBs have been widely used as a heat transfer agent and as an insulator in electrical equipment. Paints and other surface coatings such as plastics and varnishes may also contain PCBs. The denatured rapeseed oil imported from France was originally for industrial use and was treated by a "refining" process for food use in Spain. It is probable that denatured rapeseed oil had contained PCBs or that denatured oil had been contaminated with PCBs.

In fact, the world's largest and first major episode of food poisoning by PCBs occurred in Japan in 1968.¹ The disease called "yusho" (Japanese for "oil disease") is acute or subacute poisoning due to ingestion of "Kanemi rice oil" contaminated with PCBs. PCBs, used as a heat transfer medium in a deodorising process, had leaked from stainless steel pipes into the cooking oil mixture during Kanemi's manufacturing of cooking oil from rice bran. About 13 000 persons who had ingested contaminated cooking oil were affected.¹ By 1979 the Government had officially designated 1665 sufferers of the disease, including 53 deaths. The disease is characterised by various dermal, respiratory, gastrointestinal, endocrinological, and neurological manifestations.

There seems to be some relationship between toxic oil syndrome in Spain and yusho in Japan. Has the possibility of PCB poisoning ever been ruled out by measuring the concentration of PCBs in the blood and tissues of patients with toxic oil syndrome?

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¹ Reich MR. Kanemi oil poisoning incident. In: *Kodansha encyclopedia of Japan* (4). Tokyo: Kodansha, 1983.

Diagnosis of lung cancer by fiberoptic bronchoscopy: problems in the histological classification of non-small cell carcinomas

SIR.—In their paper on diagnosis of non-small cell lung carcinoma by fiberoptic bronchoscopy (March 1984; **39**: 175) Dr MT Chuang and colleagues reported that in 38% of 107 cases the histological type found in a resected specimen differed from that previously diagnosed from bronchoscopic biopsy specimens. The authors did not refer

Thorax 1984; **39**: 685-686

to two similar studies which found disagreement between bronchoscopic biopsy specimens and eventual diagnosis in only 9.1% of 233 cases¹ and 11.7% of 94 cases² of non-small cell lung carcinoma. Diagnostic criteria were similar in all three studies.

Dr Chuang and his colleagues suggested that the inaccuracy of prediction of cell type might be due to the small size of biopsy specimens taken through the fiberoptic bronchoscope. However, it has been shown that the error rate for cell type prediction is no greater with fiberoptic bronchoscopic biopsy specimens than with the larger biopsy specimens obtained at rigid bronchoscopy.² It has been shown that the diagnostic yield of fiberoptic bronchoscopic biopsies increases with the number of specimens taken³ and the experience of the bronchoscopist.⁴

Factors responsible for the variable diagnostic accuracy of bronchoscopic biopsy reported in various studies may include the number of samples taken at each bronchoscopy and the skill of the bronchoscopists and pathologists concerned.

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¹ Payne CR, Hadfield JW, Stovin PG, Barker V, Heard BE, Stark JE. Diagnostic accuracy of cytology and biopsy in primary bronchial carcinoma. *J Clin Pathol* 1981; **34**: 773-8.

² Rudd RM, Gellert AR, Boldy DAR, et al. Bronchoscopic and percutaneous aspiration biopsy in the diagnosis of bronchial carcinoma cell type. *Thorax* 1982; **37**: 462-5.

³ Gellert AR, Rudd RM, Sinha G, Geddes DM. Fiberoptic bronchoscopy: effect of multiple bronchial biopsies on diagnostic yield in bronchial carcinoma. *Thorax* 1982; **37**: 684-7.

⁴ Gellert AR, Rudd RM, Sinha G, Geddes DM. Fiberoptic bronchoscopy: effect of experience of operator on diagnostic yield of bronchial biopsy in bronchial carcinoma. *Br J Dis Chest* 1982; **76**: 397-9.

**This letter was sent to the authors, who reply below.

SIR.—Drs Gellert and Rudd are correct to bring articles with supposed contrary data to our attention. However, in the paper by Payne *et al* (ref 1 above) comparing sputum, bronchial aspirate, and needle biopsy and bronchoscopic forceps biopsy specimens discrepancies between the results of these procedures and diagnosis based on eventual surgical biopsy were also common in large cell carcinoma. The explanation for their better overall agreement between bronchial biopsy and eventual tissue diagnosis may be the marked difference in the type of carcinomas in the two series. Their series was heavily weighted in favour of squamous cell carcinoma, while this cell type comprised only one quarter of our group.

While Rudd *et al* have reported comparable degrees of accuracy with fiberoptic bronchoscopy and rigid bronchoscopy (ref 2 above) their comparison is not relevant to our study. Indeed, most of the carcinomas we encountered were peripheral, well beyond the visibility of the flexible instrument, and were biopsied under fluoroscopic control. Biopsy via the rigid bronchoscope would have been impossible.