Endoscopic palliation of tracheobronchial malignancies

I read with interest the review by Drs M R Hetzel and S G T Smith (May 1991;46:325–33). I think that cryotherapy is almost unknown in England, and used in only one centre.1

There are some errors regarding cryotherapy. The bronchial probes now use nitrous oxide and not liquid nitrogen. The temperature obtained on the tip of the probe reaches −70°C (or −80°C) but the tumour or tissues are frozen at −40°C. No cases of perforation have been reported with this technique. Flexible probes were not described by Sanderson;2 he used rigid cryosurgery (a fact I was the first to use flexible probes in 1985). The authors say that no comparative studies of laser treatment and cryotherapy have been published but there is one study in a French journal,3 and others.4,5

This technique is well known in France and used more widely than laser therapy. There are at the moment 75 cryotherapists and 1500–2000 patients have been treated.6

The technical problems of cryotherapy have been less popular than laser photoresection.

The papers cited by Dr Homason make the additional point, which we should have included, that the response to cryotherapy is relatively slow. This is clearly a disadvantage in severe airways obstruction, where an immediate response may be achieved with the laser. The greater safety claimed by cryotherapy is that, presumably, they cannot treat the most severe and life threatening obstructions, which are also likely to carry the greatest operative risk.

The comparison of laser and cryotherapy quoted1 is interesting, but only eight patients were included in each treatment group. They were apparently selected by the authors as most suitable for one or other technique. Although the cryotherapy group apparently did better, only two of the five laser failures subsequently benefited from cryotherapy. Studies like this are clearly desirable, but we need much larger numbers and no bias in patient selection if useful comparisons are to be made.

I would like to have read Dr Homason's views on our point that, although cryotherapy is claimed to be safer, several initial treatment groups are given by cryotherapists as opposed to the single treatment used by most laser bronchoscopists. This still seems to me to be an important disadvantage for patients with very limited survival, who might perhaps prefer a possible greater operative risk with laser resection if fewer admissions for treatment were required than is apparently the case with cryotherapy.

M R HETZEL
Department of Thoracic Medicine,
Uniwersity College Hospital,
London WC1E 6AU


Pulmonary function in chronic renal failure: effect of dialysis and transplantation

We read with interest the pulmonary function data compiled by Drs A Bush and R Gabriel for patients with renal transplants and patients with chronic renal failure (June 1991;46:424–8). The authors' proposal that lung function change in the groups with chronic renal failure resulted from pulmonary oedema would be consistent with the published data on patients with chronic congestive cardiac failure. For example, Wright et al have described diffusion impairment in 31% of patients awaiting heart transplantation and as many as 67% of their patients have diffusion abnormalities if those who also have restrictive and obstructive change are included.1

The suggestion of a reduction in carbon monoxide transfer factor (TLCO) in patients with renal transplants is not new. Reduced TLCO has been described in recipients of cadaveric renal allografts during active cytomegalovirus infection, who were compared with 12 control patients with renal transplants.2 It has been suggested that there is a causal relation between complement activation and the TLCO change in these patients with cytomegalovirus infection. Do Drs Bush and Gabriel have information on whether their patients with renal transplants were infected with cytomegalovirus?

AUTHOR'S REPLY

I thank Dr Homason for his helpful comments. We tried to give a balanced view on endoscopic palliation techniques and I believe that this has been the most comprehensive review to date. However, the space available for individual techniques was limited. Our review was primarily intended for British readers, among whom cryotherapy has been less popular than laser photoresection.

The papers cited by Dr Homason make the additional point, which we should have included, that the response to cryotherapy is relatively slow. This is clearly a disadvantage in severe airways obstruction, where an immediate response may be achieved with the laser. The greater safety claimed by cryotherapy is that, presumably, they cannot treat the most severe and life threatening obstructions, which are also likely to carry the greatest operative risk.

The comparison of laser and cryotherapy quoted1 is interesting, but only eight patients were included in each treatment group. They were apparently selected by the authors as most suitable for one or other technique. Although the cryotherapy group apparently did better, only two of the five laser failures subsequently benefited from cryotherapy. Studies like this are clearly desirable, but we need much larger numbers and no bias in patient selection if useful comparisons are to be made.

I would like to have read Dr Homason's views on our point that, although cryotherapy is claimed to be safer, several initial treatment groups are given by cryotherapists as opposed to the single treatment used by most laser bronchoscopists. This still seems to me to be an important disadvantage for patients with very limited survival, who might perhaps prefer a possible greater operative risk with laser resection if fewer admissions for treatment were required than is apparently the case with cryotherapy.

M R HETZEL
Department of Thoracic Medicine,
University College Hospital,
London WC1E 6AU


Silicosis in a Himalayan village population: role of environmental dust

We read with interest the paper by Dr T Norboo and others (May 1991;46:341–3), which reports for the first time progressive massive fibrosis of the lung, in the patients, as a result of environmental dust exposure.

One patient was a woman farmer; the sex and occupation of the other two patients were not given. Environmental silica, unlike occupational silica, was thought until recently to be free of fibrogenic activity.

We have seen a Saudi bedouin woman who developed progressive massive fibrosis (conglomerate fibrosis over 1 cm seen on computed tomogram) as a complication of desert lung.2 As this occurred in a woman and has not been reported in men (who have the same exposure to environmental dust) we believe that occupation could have played a part. Our patient was regularly engaged in household chores, such as grain grinding and floor

Downloaded from http://thorax.bmj.com/ on July 3, 2017 - Published by group.bmj.com
Endoscopic palliation of tracheobronchial malignancies.

J P Homasson

Thorax 1991 46: 861
doi: 10.1136/thx.46.11.861

Updated information and services can be found at:
http://thorax.bmj.com/content/46/11/861.1.citation

These include:

Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/