LETTERS TO
THE EDITOR

Accuracy of the typical computed
tomographic appearances of fibrosing
alveolitis

We read with interest the paper by K T
Tung and colleagues (April 1993;48:334–8)
investigating the accuracy of computed
tomography (CT)—albeit the combined
views of two highly experienced chest CT
radiologists—versus conventional chest
radiography in discriminating between
fibrosing alveolitis and other diffuse lung
diseases.

Although we believe that CT scanning
has advantages over conventional chest
radiography and may reduce the need for
formal open lung biopsy in a diagnosis of
fibrosing alveolitis, their paper surely over-
estimates its usefulness.

Of their study group of 41 patients with
cryptogenic fibrosing alveolitis a commend-
able 32 were confirmed histologically.
However, the inclusion of a further nine
patients with clinical and radiological
evidence of disease without histological
confirmation results in an overestimate of
the diagnostic usefulness of CT scanning. It
would be interesting to see the sensitivity,
specificity, and accuracy data limited to
just the 32 patients with open lung biopsy
evidence supporting the clinico-radiological
diagnosis of cryptogenic fibrosing alveolitis.

P BROWN
Respiratory Medicine Unit,
Western General Hospital, Edinburgh EH4 2XU
C SELBY
Department of Medicine,
Royal Infirmary, Edinburgh EH3 9YW

Respiratory symptoms questionnaire
for asthma epidemiology: validity and
reproducibility

We are grateful to Dr AM Donoghue
(August 1993;48:871) for the suggestion that
our asthma questionnaire1 would be useful
for epidemiological studies of occu-
pational asthma when combined with ques-
tions designed to elicit a temporal relation
with work. We have recently completed a
study of laboratory animal workers and
flour workers in which we used the asthma
questionnaire in conjunction with the fol-
lowing:
1. Has your chest ever felt tight or your
breathing become difficult? Yes/No
2. Has your chest ever sounded wheezing
or whistling? Yes/No
If Yes to 1 or 2 then:
3. What happens or happened to this at
weekends? Better/same/worse
4. What happens or happened to this on
holidays of a week or more? Better/same/

worse
5. Do or did you get chest tightness, diffi-
culty in breathing, chest wheezing or
whistling on contact with rat or mouse, or
their tissue, faeces or urine (or on contact
with flour or grain)? Yes/No
Work related respiratory symptoms
(WRS) were said to be present if there was
a positive reply to either questions 1 or 2
and any of 3, 4, or 5. In those reporting
two or more symptoms in the asthma
questionnaire there was a significantly high-
er prevalence of both WRS and non-work
related symptoms (NWRS) as shown in the
table.

The questionnaire1 was designed to
detect symptoms of current bronchial
hyperresponsiveness and we have no infor-
mation on its use in detecting episodes of
past symptoms. We are currently examining
the relation between responses to the
asthma questionnaire and diurnal variability
in peak expiratory flow in these two occupa-
tional groups.

K P MCKINLAY
K M VENABLES
Department of Occupational and
Environmental Medicine,
National Heart and Lung Institute,
London SW3 6NP

1 Venables KM, Farrer N, Sharp L, Grangeek
BJ, Newman Taylor AJ. Respiratory
symptoms questionnaire for asthma epide-
miology: validity and reproducibility. Thorax

Diagnostic rigid and flexible oeso-
gaphoscopy in carcinoma of the
oesophagus: a comparison

In their comparative study of rigid and
flexible oesophagoscopy AJ Ritchie and
colleagues (February 1993;48:115–8) con-
cluded that the chance of diagnosing
carcinoma was significantly greater with
the rigid oesophagescope. They also stated
that, wherever direct visualisation of the
lesion was achieved with either the flexible or rigid
instrument, biopsy was usually successful. It
seems odd, however, that the authors,
instead of providing an explanation, opted
to remain silent over the 100% failure rate
for diagnosing carcinoma in the upper third
of oesophagus as shown in table 3 of their paper.

While demonstrating the advantage of
the rigid over the flexible oesophagoscope
in terms of high diagnostic yield at no extra
risk of perforation of the oesophagus, the
authors have overlooked the inherent risks
of general anaesthesia compared with local
anaesthesia. They ignored this aspect even
in their suggestion for a randomised clinical
trial to estimate the potential influence of
the skill of the operator compared with the
limitations of the instruments in obtaining a
diagnosis. Here, I may add that taking deep
and adequate biopsies under general anaes-
thesia is probably much easier than under
local anaesthesia.

L R MURMU
Department of Surgery,
All India Institute of Medical Sciences,
New Delhi 110 029, India

NOTICES

Highlights in Pneumology 1994: Lower
Respiratory Tract Infections

The 3rd international meeting of Highlights
in Pneumology on lower respiratory tract
infections will be held in Naples on 25–26
March 1994. For further information
contact Francesco de Biasio, Scientific
Secretary, Via Tripergola 4, 80072 Arco
Felice (Naples), Italy. Tel/Fax (+39) 081
7062649.

Scadding-Morriston Davies joint fellow-
ship in respiratory medicine 1994

This fellowship is available to support visits
to medical centres in the UK or abroad for
the purpose of undertaking studies related
to respiratory medicine. Medical graduates
practising in the UK, including consultants
and irrespective of the number of years in
that grade, may apply. Applicants should
submit a curriculum vitae, together with a
detailed account of the duration and nature
of the work and the centres to be visited,
confirming that these have agreed to pro-
vide the facilities required, and giving the
sum of money needed for travel and subsis-
tence. A sum of up to £12,000 can be
awarded to a successful applicant, or the
sum may be divided to support two or more
applications. Applications should be sent by
31 January 1994 to Dr I A Campbell,
Secretary to the Scadding-Morriston Davies
Fellowship, Llandough Hospital, Penarth,
South Glamorgan CF64 1XK.
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P Brown and C Selby

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