

LETTERS

Role of low-dose theophyllines in exacerbations of COPD

In the paper by Cosio and colleagues on the effect of low-dose theophylline on the anti-inflammatory effects of steroids during exacerbations of chronic obstructive pulmonary disease (COPD), the authors concluded that recovery of forced expiratory volume in 1 s 3 months after the exacerbation and low mortality (although not statistically significant) in the theophylline group, in combination with the molecular effects described, provided a strong rationale for investigating further the potential clinical relevance of this therapeutic strategy in large randomised double-blind placebo controlled trials.¹

In such trials, if the time of hospital discharge is taken as the end point instead of taking 3 months after the exacerbation as in the study by Cosio *et al*, it would better reflect the physiological events of a COPD exacerbation. In addition to addressing the limitations expressed by the authors in the article, consideration of clinical parameters such as symptoms, blood gases and the need for non-invasive ventilation in the outcome measures might add more strength to the evidence. Another factor which also needs to be considered is whether patients with COPD are on a pulmonary rehabilitation programme.

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REFERENCE

1. Cosio BG, Iglesias A, Rios A, *et al*. Low-dose theophylline enhances the anti-inflammatory effects of steroids during exacerbations of COPD. *Thorax* 2009;**64**: 424–9.

Author's reply

We are grateful for Dr Palamarthy's comments on our paper. However, we disagree with his suggestion of taking the time of hospital discharge instead of 3 months as the endpoint because the aim of our intervention was to decrease inflammation and it is well known, as reported by Perera and colleagues,¹ that inflammation and symptoms may not recover to baseline even 35 days after an exacerbation. In trials

that we are about to start, in which patients will be recruited while stable, we have considered clinical outcomes as well as inflammatory and mechanistic variables but, in our view, the time to first exacerbation and the rate of exacerbations would be more reflective of the mechanism of action that we are proposing for low-dose theophylline. Rehabilitation is important and needs to be considered for daily clinical practice, but both arms would eventually be exposed to it so it should not be a confounding factor.

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REFERENCE

1. Perera WR, Hurst JR, Wilkinson TM, *et al*. Inflammatory changes, recovery and recurrence at COPD exacerbation. *Eur Respir J* 2007;**29**: 527–34.

Risk disclosure prior to bronchoscopy

We read with great interest the recent article by Uzbeck *et al*¹ demonstrating increased anxiety in patients following detailed risk disclosure prior to bronchoscopy. This timely well-conducted study engages with the challenging area of informed consent, and the authors eloquently outline the difficulties in balancing patient autonomy and physician desire to minimise patient anxiety but also to avoid litigation. We agree that the small increase in patient anxiety following explicit consent "seems a price worth paying for most patients". We wish to comment, however, on a couple of methodological issues.

The study information sheets were provided on the day of bronchoscopy which allowed little time to rationalise the information and also discussed prominently the complications of transbronchial biopsy, although not all patients would have undergone this riskier procedure.

We have recently surveyed the consenting practices of 33 respiratory physicians in the north-east of England. Thirty-one respondents always provided procedural information prior to bronchoscopy and 2 often did so (verbal and written 26, verbal only 6, written only 1). Thirty respondents always, 2 often and 1 never explained the indication for performing bronchoscopy. There was a wide variation in individual consenting practices

Risk Disclosure in Bronchoscopy

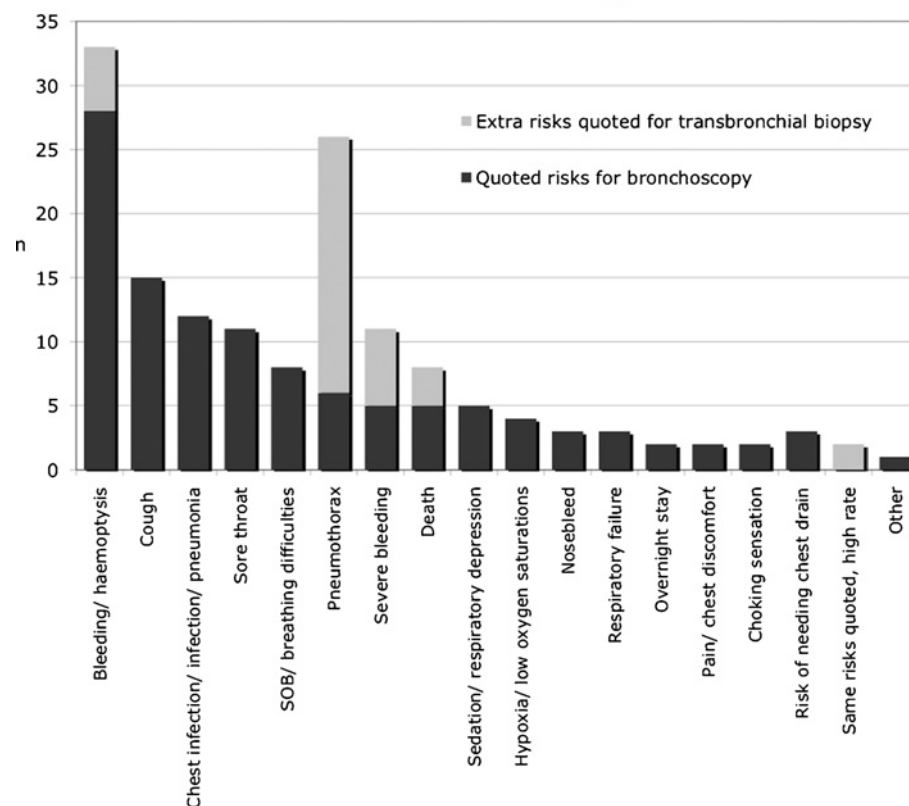


Figure 1 Risk disclosure in bronchoscopy.