Correspondence on the paper by Bridevaux et al

We read with interest the important prospective natural history study of respiratory virus infections (RVI) in lung transplant recipients by Bridevaux et al.1

Although the authors were unable to find an association between acute rejection and RVI, they acknowledge the possibility that RVI might predispose to chronic rejection, bronchiolitis obliterans syndrome (BOS). The association between BOS and RVI has been highly discussed in the literature, but a recent meta-analysis by Vu et al2 remained inconclusive on the connection. In view of this, we wonder whether the authors have analysed the association of incident RVI with BOS in their cohort.

We were surprised at the authors’ conclusion that “…asymptomatic carriage is rare” for several reasons. First, the frequency of surveillance testing did not appear to be frequent enough to exclude a high rate of self-resolving infections (ie, infections may have occurred between screening tests). Second, we note that RVI were detected in 14% of routine screening/surveillance visits. And finally, the proportion of positive viral tests was 10% at screening visits even among those without any symptoms. These data all suggest that RVI might be substantially more common than previously recognised and not necessarily predicted by symptomatology. It was unclear from the Methods section whether bronchoscopies were performed for surveillance or only for cause. It would be of interest if the authors could clarify this issue and provide positivity rates of bronchoalveolar lavage done for surveillance versus for cause.

Future studies will be needed to define any significance (or not) of asymptomatic versus symptomatic RVI in terms of clinically relevant outcomes (risk for subsequent bacterial/fungal superinfection, chronic allograft injury/dysfunction, etc).

An additional point of interest is the connection between viral infection of the upper and lower respiratory tracts. We wonder whether the authors could supply any data to support the assumption that infections are first identifiable in the upper airways before progressing to the lungs.

We thank the authors for their continued investigation of this important topic and informative paper.

Carl M Preiksaitis, Ajit P Limaye
Division of Infectious Disease, Department of Medicine, University of Washington, Seattle, Washington, USA

Correspondence to Ajit P Limaye, Division of Infectious Disease, Department of Medicine, University of Washington, Seattle, WA 98195, USA; limaye@uw.edu

Correction notice This article has been corrected since it was published Online First. The correspondence details have been amended.

Contributors The article was equally written and researched by APL and CMP.

Competing interests None.

Provenance and peer review Not commissioned; internally peer reviewed.

To cite Preiksaitis CM, Limaye AP. Thorax 2014;69:82.

Received 3 October 2013
Accepted 30 October 2013
Published Online First 19 November 2013

Thorax 2014;69:82.
doi:10.1136/thoraxjnl-2013-204610

REFERENCES
Correspondence on the paper by Bridevaux et al

Carl M Preiksaitis and Ajit P Limaye

Thorax 2014 69: 82 originally published online November 19, 2013
doi: 10.1136/thoraxjnl-2013-204610

Updated information and services can be found at:
http://thorax.bmj.com/content/69/1/82.1

These include:

References
This article cites 2 articles, 1 of which you can access for free at:
http://thorax.bmj.com/content/69/1/82.1#BIBL

Email alerting service
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/