Thorax, 1981, **36**, 400

Correspondence

Sequential brush biopsy and conventional biopsy: direct comparison of diagnostic sensitivity in lung malignancy

Sir,—This report by Dr Lyall and his colleagues in the December 1980 issue of *Thorax* (p 929) compares brush biopsies through the flexible fibreoptic bronchoscope with conventional biopsies taken for histological examination through the rigid bronchoscope. Their claim that the first method "is the diagnostic technique of choice for patients with suspected lung malignancy" seems to carry the implication that brush biopsy is best performed through a fibreoptic bronchoscope. It is, in fact, just as easy to obtain satisfactory brush biopsies through a rigid bronchoscope, and if the Storz flexible director is used, the brush can be inserted into any segmental bronchus, including those of the upper lobe. Furthermore, it is possible to take much deeper biopsies (with a better prospect of making a positive tissue diagnosis) from extramural lesions in the larger bronchi than can be obtained with the small and delicate forceps which have to be used with fibreoptic bronchoscopes.

If the report was not intended to perpetuate the rather sterile controversy on the respective merits of fibreoptic and rigid bronchoscopy, I wonder why the authors chose to compare the results of brush biopsy and tissue biopsy by using different bronchoscopic methods to obtain the two types of specimen. In that context it is impossible to assess the validity of the comparison without information about the macroscopic nature of the lesions from which the biopsies were taken, and there is the further point that bleeding after bronchial brushing may make it more difficult to obtain a "good" tissue biopsy specimen.

Both fibreoptic and rigid bronchoscopy have advantages and disadvantages too numerous to mention in a short letter, and in some centres the two techniques are used in combination. Surely the time has come to agree that equipment for both types of bronchoscopy, and the expertise to use it, should be available in all medical and surgical respiratory units.

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Sir,—In reply to Dr Grant we must emphasise that our comparison was between brush biopsy and conventional biopsy with Brock biopsy forceps. We only included lesions which were in range of the rigid bronchoscope so that the two biopsy techniques could be directly compared. The point that we have tried to make is that cytological methods seem to be very much more sensitive than conventional biopsy. We chose to perform the brushings through the fibreoptic bronchoscope as this is part of our routine bronchoscopic examination. We also feel that direction of the brush under close direct vision, as can be performed through the fibreoptic bronchoscope, makes the brushing technique rather simpler. We would agree that both fibreoptic and rigid bronchoscopic facilities should be available simultaneously. Although brushing may cause bleeding, this is very much less than that resulting from biopsy with Brock forceps and we feel that the high sensitivity of brush biopsy coupled with the minimal bleeding, make brush biopsy the preferred diagnostic method.

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Laennec

SIR,—Some readers may have been intrigued by the quaint French words *muquex* and *senore* attributed to Laennec in the table on p 102 of the February issue, and perhaps taken them as archaic forms. What Laennec wrote, however, and what Forbes reproduced in his contemporary translation, was *muqueux* and *sonore*.

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The editor pleads guilty to having missed these errors in the proof. Fortunately the correct spelling got through on p 86 of the same issue.

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