11 **Cerfolio RJ**, Bryant AS, Ohja B, *et al*. The maximum standardized uptake values on positron emission tomography of a non-small cell lung cancer predict stage, recurrence, and survival. *J Thorac Cardiovasc Surg* 2005;**130**:151–9.
12 **De Wever W**, Ceyssens S, Mortelmans L, *et al*. Additional value of PET-CT in the staging of lung cancer: comparison with CT alone, PET alone and visual correlation of PET and CT. *Eur Radiol* 2007;**17**:467–73.
13 **Kramer H**, Groen HJ. Current concepts in the mediastinal lymph node staging of nonsmall cell lung cancer. *Ann Surg* 2003;**238**:180–8.
14 **Toloza EM**, Harpole L, Detterbeck F, *et al*. Invasive staging of non-small cell lung cancer: a review of the current evidence. *Chest* 2003;**123**(1 Suppl):157–66S.
15 **Paquet N**, Albert A, Foidart J, *et al*. Within-patient variability of (18)F-FDG: standardized uptake values in normal tissues. *J Nucl Med* 2004;**45**:784–8.
16 **Lee JR**, Madsen MT, Bushnel D, *et al*. A threshold method to improve standardized uptake value reproducibility. *Nucl Med Commun* 2000;**21**:685–90.
17 **Vansteenkiste JF**, Stroobants SG, De Leyn PR, *et al*. Lymph node staging in non-small-cell lung cancer with FDG-PET scan: a prospective study on 690 lymph node stations from 68 patients. *J Clin Oncol* 1998;**16**:2142–9.
18 **Shim SS**, Lee KS, Kim BT, *et al*. Non-small cell lung cancer: prospective comparison of integrated FDG PET/CT and CT alone for preoperative staging. *Radiology* 2005;**236**:1011–9.
19 **de Langen AJ**, Raijmakers P, Riphagen I, *et al*. The size of mediastinal lymph nodes and its relation with metastatic involvement: a meta-analysis. *Eur J Cardiothorac Surg* 2006;**29**:26–9.

LUNG ALERT

COPD and MI: a bad combination

▲ Salisbury AC, Reid KJ, Spertus JA. Impact of chronic obstructive pulmonary disease on post-myocardial infarction outcomes. *Am J Cardiol* 2007;**99**:636–41.

In this observational prospective multicentre study that enrolled 2481 patients, the authors tried to highlight the relationship between chronic obstructive pulmonary disease (COPD) and a number of outcomes following an acute myocardial infarction (MI).

One-year mortality and rehospitalisation rates were significantly higher in patients with COPD than without (15.8% vs 5.7%) and (48.7% vs 38.6%), respectively. In addition, patients with COPD had worse health status at baseline as well as at 1 year and a trend toward a higher prevalence of angina at 1 year. Not surprisingly, patients with COPD had fewer coronary revascularisation procedures and less use of β blockers, aspirin and cardiac rehabilitation.

With the well-documented role of β blockers in improving survival post-MI even in patients with COPD, it is possible that more frequent usage of these agents, particularly the cardio-selective agents, in the study population could have led to a better 1 year survival than observed and possibly a lower prevalence of angina, again at 1 year.

The study used clinical rather than pulmonary function test definition of COPD and as a consequence could have misclassified some patients with possible inclusion of non-COPD patients, for example those with asthma. Furthermore, the outcomes could have been influenced by the severity of COPD, which the authors were unable to classify. Nevertheless, the data suggest that patients with acute MI and COPD have a substantially worse prognosis in terms of mortality and health status. This cohort of patients therefore warrants careful attention and closer follow-up.

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