

rates are clearly significant, favouring varenicline over nicotine replacement therapy (NRT) ($p = 0.04$).

In addition, while Hillman *et al* question the justification of the additional cost of varenicline over NRT, the NICE technology appraisal guidance concluded that, over a lifetime, varenicline is more cost-effective than both bupropion SR and NRT.⁵

In conclusion, we feel that we honestly reported our results, not claiming any superiority of varenicline over NRT in the long term, either in the abstract or in the conclusion of the paper. Rather, we hoped to convey the message that any intervention shown to be at least as clinically effective as NRT is an important additional option for smokers attempting to quit.

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CORRECTION

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G C Donaldson, T A R Seemungal, A Bhowmik, and J A Wedzicha. Relationship between exacerbation frequency and lung function decline in chronic obstructive pulmonary disease. *Thorax* 2002;**57**:847–52.

The legend for fig 2 should read: "Change in FEV₁ with standard errors over 4 years. Open circles represent frequent exacerbators; closed circles represent infrequent exacerbators."

Pulmonary puzzle

ANSWER

From the question on page 746

The differential diagnosis for pulmonary infiltrates in the immunocompromised host includes opportunistic infections, drug toxicity, alveolar haemorrhage and progression of the primary disease. The diagnostic yield of bronchoscopy in immunocompromised patients with lung infiltrates is variable with a higher yield (~81%) for infectious aetiologies. On the basis of the larvae in the bronchoalveolar lavage fluid, our case was diagnosed as *Strongyloides* hyperinfection.

Strongyloidiasis is caused by an infection with *Strongyloides stercoralis*, a helminth that can complete its life cycle entirely within the human host.¹ This autoinfection permits the organism to persist for decades and allows hyperinfection to occur in states of impaired cell-mediated immunity.² Detection of a large number of larvae in the stool and/or bronchoalveolar lavage fluid or sputum is a hallmark of hyperinfection. The diagnosis requires a high index of suspicion and patients who have peripheral eosinophilia, serpiginous rash or history of soil exposure in tropical and subtropical areas should be screened by stool studies before any form of immunosuppression. In disseminated disease or steroid exposure eosinophilia may be absent.

The respiratory symptoms in strongyloidosis are caused by the migrating larvae producing alveolar haemorrhage, oedema or inflammatory changes. Adult worms are known to cause chronic bronchitis or asthma-like symptoms. The chest radiograph or a CT scan in those with clinical signs and symptoms will usually show abnormal findings including fine miliary nodules or diffuse reticular infiltrates. As the infection progresses there may be bronchopneumonia with scattered ill-defined alveolar, segmental or even lobar opacities similar to those seen in Löffler's syndrome or eosinophilic pneumonitis.

The current treatment of choice for strongyloidiasis is ivermectin with albendazole as an alternative. Our patient was treated with ivermectin for 5 days. He was extubated and his nodular infiltrates cleared slowly over 6 weeks.

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