Is investigation of patients with haemoptysis and normal chest radiograph justified?

We read with interest the article by Thirumaran et al. They described their experience of 270 consecutive patients referred with haemoptysis and a normal chest radiograph. In their study they found the incidence of respiratory malignancy within this group was 9.6% (26 individuals) and of these 22 were primary lung malignancies. This is slightly higher than the 3–6% incidence previously reported in the literature.1–3

We have delivered a nurse-led clinic for patients referred via the 2 week wait system with haemoptysis and a normal chest x-ray. In their study they found the incidence of respiratory malignancy within this group was 9.6% (26 individuals) and of these 22 were primary lung malignancies. This is slightly higher than the 3–6% incidence previously reported in the literature.1–3

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The authors are to be commended on using CUSUM to calculate the learning curves associated with endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA). The retrospective study from five centres demonstrated that variable learning periods are required to attain proficiency in the procedure, and a pooled sensitivity of 67.4% was observed.

The learning curve for EBUS-TBNA

We read with interest the paper by Kemp et al which utilises cumulative sum (CUSUM) to analyse the learning curves associated with endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA). The retrospective study from five centres demonstrated that variable learning periods are required to attain proficiency in the procedure, and a pooled sensitivity of 67.4% was observed.

The authors are to be commended on using CUSUM to calculate the learning curves for EBUS-TBNA; however, several points deserve comment. First, the study only includes patients undergoing EBUS-TBNA for the diagnosis or staging of lung cancer. In clinical practice, the procedure is also commonly employed for the diagnosis of isolated mediastinal lymphadenopathy, and these procedures should be incorporated in the learning process. Secondly, the authors included non-malignant nodes in the CUSUM analysis. Therefore, it may be possible to inadequately sample a benign node and for the result to be assigned as a true negative. This highlights the importance of reporting the disease prevalence for each cohort. Thirdly, utilising the criteria employed in this paper, there is potential to perform tissue diagnosis in patients diagnosed with a thoracic malignancy.

Table 1 common diagnostic causes of haemoptysis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>23</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>52</td>
</tr>
<tr>
<td>Infection</td>
<td>107</td>
</tr>
<tr>
<td>Idiopathic</td>
<td>70</td>
</tr>
<tr>
<td>ENT</td>
<td>24</td>
</tr>
<tr>
<td>Cardiac</td>
<td>6</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>5</td>
</tr>
<tr>
<td>Not haemoptysis</td>
<td>34</td>
</tr>
<tr>
<td>Anticoagulation therapy</td>
<td>8</td>
</tr>
<tr>
<td>Vascularity</td>
<td>4</td>
</tr>
<tr>
<td>DNA follow-up</td>
<td>13</td>
</tr>
<tr>
<td>Died</td>
<td>2</td>
</tr>
</tbody>
</table>

The clinic ceased to run in January 2009 and, to date, no patients have been re-referred or appeared on the cancer database. This would also suggest that our model is a safe, efficient method of screening patients with a possible thoracic malignancy and freeing up resources in the urgent 2 week wait clinic.

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