I read with great interest the article by Coutinho et al. [1]. The aim was to determine accuracy of diagnosis based on clinical data and imaging for pulmonary infiltrates compared with the result of the surgical lung biopsy (SLB). The methodology used was as follows: presumptive diagnosis was based on clinical data, imaging and non-invasive or minimally invasive diagnostic procedures. This is compared with what they called the diagnostic gold standard of histological diagnosis by surgical lung biopsy. The whole study is designed as if histopathologic diagnosis is the gold standard. As a result of this they draw the following conclusions: SLB is a safe and accurate diagnostic tool for pulmonary infiltrates of unknown aetiology and in the opinion of the authors SLB remains the gold standard for undiagnosed or incompletely diagnosed diffuse pulmonary disease.

I would like to draw attention to the fact that histopathology in diffuse parenchymal lung disease (DPLD) is not the gold standard. There is a vast amount of literature that shows clearly the shortcomings of diagnosis based on histopathology alone. First of all there is the problem of the interobserver variation between pathologists interested in DPLD with an overall kappa value of only 0.38 for pathologists specialised in DPLD [2]. The major role of biopsy in idiopathic interstitial pneumonias is to rule out a UIP pattern, which is hampered by the high interobserver histologic variability. This is addressed in the study of Flaherty et al. [3] who studied the frequency of coexistence of histologic patterns suggestive of NSIP and UIP in 26% of patients. The main reason to rule out a UIP pattern is because the prognosis of the latter is extremely poor. An important observation in this regard is that of Latsi et al. that in severe disease with DLCO <35% the prognosis of NSIP equals the prognosis of UIP which makes a biopsy pointless to predict prognosis if DLCO is <35% [4].

Due to these problems the ATS/ERS consensus statement suggests another method to arrive at a confident diagnosis [5]. This method consists of a formal meeting with respiratory physicians, radiologists and histopathologists where the clinical, radiological and pathological data are discussed and a diagnosis is made.

In conclusion the study of Coutinho et al. clearly showed that SLB is a safe and accurate diagnostic tool for pulmonary infiltrates of unknown aetiology. It is also correct that this procedure is indicated in cases in which clinical or imaging findings are atypical or when the presumed diagnosis has a low degree of certainty. But in DPLDs it has been shown that in no way SLB can be the gold standard for undiagnosed or incompletely diagnosed diffuse pulmonary disease. The

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Surgical lung biopsy is not the golden standard in diagnosis of diffuse parenchymal lung diseases

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method that reaches highest grade of accuracy is a formal meeting in which clinical, radiological and histopathological data are discussed and a final consensus diagnosis is made.

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**Reply to the Letter to the Editor**

**Reply to Wuyts**

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We are very pleased with the interest shown in our paper [1] by Dr Wuyts [2], an expert in the field of interstitial lung disease.

The main objective of our study was to determine the overall and disease-related accuracy of the clinical-imagingological diagnosis by comparing it with the histological result of surgical lung biopsy (SLB), for indeterminate pulmonary lesions/infiltrates. For the purpose of our study we considered SLB as the final diagnosis, even though it may not be entirely accurate and is sometimes inconclusive, as it was the only means to ascertain if a presumptive diagnosis (clinical-imagingological) was correct.

It was not our intention to establish new ‘guidelines’ to the approach to diffuse parenchymal lung disease (DPLD), because they are well described in the 2002 ATS/ERS consensus statement [3] and, as was well pointed out by Wuyts, the diagnosis is a dynamic process of which the opinion of the respiratory physician, radiologist and histopathologists are integral parts. Even so, the ATS/ERS consensus statement indicates ‘surgical biopsy is necessary for a confident clinicopathogic diagnosis except in cases with a typical clinical-radiological picture of UIP/IPF’, as we mentioned in the discussion section of our paper.

Besides our own institution, we receive patients from primary and secondary centres and from isolated chest physicians; hence not all the patients had the opportunity to have their case discussed in a formal meeting of experts. On the other hand, this handicap was attenuated by precise clinical information, detailed radiological features, particularly from CT scans, and operative findings given to the pathologist together with the biopsy specimen. Therefore, the SLB result was never a strictly microscopic observation but an integrated diagnosis between clinical—radiological—pathological and surgical findings.

From this point of view, therefore, we dispute Wuyts’ opinion regarding the appropriateness of the methodology we have used and still have to consider the histological diagnosis as the gold standard. Our conclusion that ‘SLB is a safe and accurate diagnostic tool for pulmonary infiltrates of unknown aetiology, and, in our opinion, remains as the gold standard for undiagnosed or incompletely diagnosed diffuse pulmonary disease’ is, we believe, vindicated by our study in this particular setting and not specifically to patients labelled as having DPLD.

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**Letter to the Editor**

**The optimal timing to resect pulmonary metastasis**

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Keywords: Pulmonary metastasis; Metastectomy; Opportunity for pulmonary resection; Tumour size; Histology

I would like to congratulate Tanaka et al. with regards to their findings on the optimal timing to resect pulmonary...