From the authors:

We thank D. Stanescu for his interest in our paper [1] and for giving us the opportunity to clarify an important methodological issue. First of all, we would like it to be remembered that our document was intended for use in designing clinical trials on pharmacological treatments of chronic obstructive pulmonary disease. The point we wanted to make clear is that, because of the well known potential errors inherent to dilution methods and body plethysmography [2–4], they should not be used interchangeably within a clinical trial. We are aware that keeping the panting frequency below 1 Hz helps reduce overestimation of lung volumes measured by body plethysmography in the presence of airflow obstruction [5, 6], but this has to be confirmed in very severe chronic obstructive pulmonary disease and it may not be easily feasible in large multicentre clinical trials. Notwithstanding, we agree that, whenever possible, the plethysmographic method should be adopted, not only because it is less time consuming, but also because it allows assessment of repeatability of measurements within sessions and, thus, better quality control.

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STATEMENT OF INTEREST

Statements of interest for M. Cazzola and V. Brusasco can be found at www.erj.ersjournals.com/misc/statements.shtml

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DOI: 10.1183/09031936.00056808

Improvement with long-term itraconazole therapy for *Fonsecaea pedrosoi*-related mediastinal phaeohyphomycosis

To the Editors:

In the September 2006 issue of the *European Respiratory Journal*, we reported the first culture-proven case of mediastinal mass due to *Fonsecaea pedrosoi* that had been successfully managed medically [1]. Maintenance therapy with oral itraconazole 100 mg *b.i.d.* was continued for a total of 3 yrs. This decision was taken in view of the rarity of the disease, paucity of data on the management of such cases and good clinico-radiological response to 6 months of therapy with this antifungal agent.

During this time period, the patient continued to experience clinical improvement, in the form of complete resolution of the dyspnoea and dysphagia that had mandated tracheostomy and feeding jejunostomy, respectively, at the time of initial presentation. Hoarseness of voice had also improved significantly with speech therapy. The patient is now able to carry out all activities of daily living and has restarted his professional work. The patient was assessed with repeat computed tomography (CT) scans of the thorax at 1-yr intervals. A significant regression in the size of the mediastinal mass was also observed on CT (fig. 1). In view of the patient's clinical and radiological stability, itraconazole treatment has now been stopped and a close follow-up planned.

The authors' aim behind this communication is only to stress the fact that long-term itraconazole therapy may help to achieve sustained improvement followed by stability in both clinical symptoms and radiological lesions of patients with this rare entity.