

Sporadic and epidemic community legionellosis: two faces of the same illness

To the Editors:

We read with interest the article of SOPENA *et al.* [1] on the comparisons of risk factors, presentation and outcome of community-acquired *Legionella pneumophila* pneumonia in 138 sporadic-case patients (1994–2004) and 113 outbreak-case patients (2002). As suggested by the authors, a limitation of comparison on the clinical severity between the two populations could be related to the delay in diagnosis. In other words, in the case of an outbreak, many exposed patients were screened for legionellosis using urinary antigen assays so that patients with mild symptoms could be diagnosed and treated. Conversely, sporadic cases were more frequently diagnosed, such as when the patients were hospitalised due to the severity of their symptoms. This corresponds to a more typical presentation and detection of the disease. A means to test this hypothesis would be to calculate the delay between the onset of the disease and the time of *Legionella* urinary antigen detection within the two groups of patients, and then compare the severity of the symptoms adjusted with these delays. It would be reasonable to suppose that for a similar delay in diagnosis, the clinical features would be the same for sporadic and outbreak cases. If differences persisted after adjustment for delays in diagnosis, then specific determinants would need to be identified in relation to the severity of the legionellosis within these two populations.

Similarly, as demonstrated in some studies performed among patients with cancer [2], this investigation would face a bias due to the earlier time of diagnosis associated with a screening procedure called “lead-time” and would possibly lead to over-diagnosis.

P. Vanhems^{*,#}, S. Pires-Cronenberger[#] and C. Lasset^{*,†}

^{*}University of Lyon 1, UMR CNRS 5558, Villeurbanne

[#]Infection Control Unit, Edouard Herriot Hospital, and [†]Unit of Prevention and Genetic Epidemiology, Centre Léon Bérard, Lyon, France.

STATEMENT OF INTEREST

None declared.

REFERENCES

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Benefits of a modified spirometry technique

To the Editors:

We applaud the American Thoracic Society (ATS) and the European Respiratory Society for their continuing efforts to optimise pulmonary function testing practice through disseminating guidelines, such as the recent spirometry guidelines [1]. In reviewing this document, we wish to point out a spirometry practice that, although mentioned (but not endorsed) in the guidelines, can, in our experience, substantially improve and streamline the performance of spirometry by pulmonary function laboratories [2]. Specifically, we point out the benefits of a modified spirometry technique in which the expiratory effort is relaxed after the first 3 s of expiration. As evaluated and reported in a small, randomised, controlled, crossover trial of two expiratory techniques and in our subsequent experience [2], four lines of reasoning support the benefits of using this modified spirometry technique to obtain high-quality measurements, as follows.

1) Enhanced satisfaction of spirometric end-of-test criteria. In the original report [1], ATS end-of-test criteria were met significantly more frequently with the modified expiratory

technique (58.3 *versus* 18.7% of sessions; $p < 0.001$). More recent experience in our laboratory, in which we have routinely used this technique since 1994 [3], confirms this initial experience, leading us to recommend this technique to others and for consideration to include in future guidelines. For example, using this technique in recent years, the mean expiratory time for patients with obstruction in our laboratory is 12.4 ± 3 s.

2) Patient preference for this modified technique. In our initial comparison of techniques and subsequent experience, patients tested with both techniques preferred the modified technique. In our original report, although comparative subjective ratings did not achieve statistical significance, trends toward more comfort and less lightheadedness with the modified technique were evident.

3) Fewer adverse effects associated with spirometry performance using the modified technique. The frequency of presyncope and syncope, although low even with the standard technique of sustained forced expiration, seems yet lower using the modified expiratory technique. Before 1994, when