but we stated that, according to our results, IFN-γ based assays could reduce unnecessary chemoprophylaxis in non-*M. tuberculosis* infected children. In fact, BAKIR *et al.* [11] in a recent study concluded that a positive IFN-γ based assay result predicted the development of active TB as well as the TST, allowing more focused preventive therapy to fewer contacts.

In conclusion, we believe our results provide enough evidence that previous NTM sensitisation induces false-positive results in the TST for diagnosing LTBI; but, we also strongly agree with TEBRUEGGE *et al.* that additional studies are needed in order to clarify different issues related to the discordant IFN-γ based assay results, and to assess the real utility in the management and benefit of a child population.

I. Latorre*,¶,+, M. De Souza-Galvão¶,§, J. Ruiz-Manzano#,¶,+, A. Lacoma*,¶,+, C. Prat*,¶,+, N. Altet§, V. Ausina*,¶,+ and J. Domínguez*,¶,+

*Servei de Microbiologia, and #Servei de Pneumologia, Hospital Universitari ''Germans Trias i Pujol'', Fundació Institut d'Investigació en Ciències de la Salut Germans Trias i Pujol, +Ciber Enfermedades Respiratorias, Instituto de Salud Carlos III, Badalona, ¶Universitat Autònoma de Barcelona, Bellaterra, and §Unidad de Prevención y Control de la Tuberculosis de Barcelona, Barcelona, Spain.

Correspondence: J. Domínguez, Servei de Microbiologia, Fundació Institut d'Investigació en Ciències de la Salut ''Germans Trias i Pujol'', Carretera del Canyet s/n, 08916 Badalona, Barcelona. Spain. E-mail: jadomb@gmail.com

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Complete smoking cessation is beneficial in older and more advanced COPD patients

To the Editors:

We read with great interest the article by TASHKIN *et al.* [1] in a recent issue of the *European Respiratory Journal* evaluating effects of smoking status on long-term responses to maintenance bronchodilator therapy in the Understanding Potential Long-term Impacts on Function with Tiotropium (UPLIFT®) trial. The UPLIFT® trial [2] is a recent investigation in a long series of clinical trials assessing, among other things, the effects of different drugs on long-term forced expiratory volume in 1 s (FEV_1) decline in patients with COPD, a ''holy grail'' of the pulmonological community.

As tobacco smoking is the most frequent risk factor for COPD, researchers in the UPLIFT® trial paid the utmost attention to smoking status of the investigated cohort. They registered smoking status at inclusion, offered smoking cessation to every smoking patient before entry and checked smoking status at each follow-up visit during the 4 yrs of study. Study participants were classified into three subgroups: continuing current smokers (CS), continuing ex-smokers (CE) and intermittent smokers (IS).

The authors concentrate on analysis of effects of tiotropium in relation to smoking status on bronchodilation, exacerbation

rate, quality of life and mortality. They acknowledge that the rate of FEV1 decline was highest in CS, and lowest in CE in both tiotropium and placebo (other treatments) subgroups. We thank the authors for highlighting this finding in their abstract, and feel that this particular finding deserves some comment.

The authors compare their study to the Lung Health Study (LHS) [3] in respect to effect of smoking status on the rate of FEV1 decline. The LHS and UPLIFT® studies have many similarities: large study groups, smoking cessation programme at entry, long-term follow-up and three smoking status subgroups. However, it is most interesting that the UPLIFT® trial is complementary to LHS [4]. LHS participants were younger, with a mean age 48.5 yrs *versus* 61–66 yrs in UPLIFT®. The majority of LHS participants were in the mild/moderate stage of COPD (mean FEV1 at 78% of predicted, range 55–90%), whereas no mild stage patients were included in the UPLIFT® trial (mean FEV1 at 40% pred, range 20–70%); 96% of participants were in the moderate or severe stage.

Interestingly, mean FEV1 decline per year in the first 5 yrs of follow-up in LHS continuing smokers was 62 $mL \cdot yr^{-1}$ *versus* 59 $mL \cdot yr^{-1}$ in the UPLIFT® CS subgroup. Continuing ex-smokers in LHS lost 31 $mL \cdot yr^{-1}$ *versus* 33 $mL \cdot yr^{-1}$ in the UPLIFT® trial; almost superimposed figures. Thus, smoking cessation was highly effective across the entire spectrum of COPD severity.

The UPLIFT® trial demonstrated that complete smoking cessation results in clinically significant reduction in FEV1 decline in COPD patients with more advanced stages of the disease, irrespective of treatment. A useful future objective for the authors would be to perform statistical analysis of differences in FEV1 decline in the three subgroups of smoking status.

This new piece of evidence resolves reservations that spectacular effects of smoking cessation on FEV1 decline demonstrated in the LHS may be limited to COPD patients with mild forms of the disease [5]. Another important message from the TASHKIN *et al.* [1] study is that only CE patients had improved survival, irrespective of treatment modality, another finding in conjunction with the results of LHS after 14.5 yrs follow-up [6]. The majority of COPD patients have cardiovascular comorbidity. Successful smoking cessation would also reduce risk for myocardial infarction or stroke.

Complete smoking cessation remains a much more effective method to stop accelerated FEV1 decline in COPD than any pharmacological agent tried so far.

The results of the UPLIFT® trial support the idea of early detection of COPD by high-risk population screening [7] or a case finding method [8]. Early diagnosis gives a unique opportunity to target that group with the full array of antismoking initiatives. All available resources should be applied to help smokers with COPD to quit smoking as a first-line treatment. Spirometry testing of smokers combined with smoking cessation clinics increase smoking cessation rate [9]. Our observational study demonstrating that 17% of smokers with spirometric signs of airflow obstruction stop smoking has recently been confirmed by large randomised controlled investigations [10]. We strongly believe that early detection of COPD combined with primary and secondary prevention measures are the best methods to reduce the burden of the disease [11].

J. Zielinski, M. Bednarek and D. Gorecka
Dept of Respiratory Medicine, National Research Institute of Tuberculosis and Lung Diseases, Warsaw, Poland.

Correspondence: J. Zielinski, Dept of Respiratory Medicine, National Research Institute of Tuberculosis and Lung Diseases, Warsaw, Poland. E-mail: j.zielinski@igichp.edu.pl

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From the authors:

We thank J. Zielinski and co-workers for their comments and concur with their conclusion that the significant and substantial benefits of complete smoking cessation and sustained abstinence with respect to reduction in the annual rate of decline in forced expiratory volume in 1 s (FEV1) that were noted in the mostly middle-aged participants in the landmark Lung Health Study [1–3] were similarly observed in older patients with more advanced chronic obstructive pulmonary disease (COPD),