

Moreover, these results are not reserved for expert centres alone. After 24 months of training, the diagnostic sensitivity of pulmonologists without experience in TBNA rose from 24 to 78% [5].

TBNA has some important advantages. 1) It can be performed during the bronchoscopic procedure that is already necessary in the work-up of patients suspected for lung cancer. The extra time is limited to a few minutes and the additional costs of a TBNA needle are ~90€. 2) The use of ultrasound is a necessity in the oesophagoscope as there are no anatomical landmarks in the oesophagus. During bronchoscopy, one can rely on several endobronchial landmarks to localise lymph nodes. In the only randomised trial in the literature concerning the use of ultrasound-guided *versus* "blind" TBNA, there was no significant difference in the diagnostic yield of subcarinal lymph nodes [8]. 3) It is a cost-effective procedure which may diagnose N3 disease in an important number of cases, and consequently avoid mediastinoscopy (1,550€ in our hospital) [6]. 4) From the patient's point of view, if TBNA performed during the necessary bronchoscopy is diagnostic, no additional endoscopic procedures are needed. After all, who would volunteer for oesophagoscopy?

In an editorial comment on the endoscopic approach of mediastinal lymph nodes, the vast literature on the excellent results of TBNA should not be neglected.

Before endoscopic ultrasound-guided fine-needle aspiration is proclaimed as the new gold standard, and pulmonologists are advised to learn oesophagoscopy, we should first learn to perform a routine transbronchial needle aspiration during the bronchoscopy. This approach is cost-effective and limits the number of endoscopic procedures, which may even be unnecessary. Your patient will be grateful to you!

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REFERENCES

- 1 Vilmann P, Larsen SS. Endoscopic ultrasound-guided biopsy in the chest: little to lose, much to gain. *Eur Respir J* 2005; 25: 400–401.
- 2 Rintoul RC, Skwarski KM, Murchison JT, Wallace WA, Walker WS, Penman ID. Endobronchial and endoscopic ultrasound-guided real-time fine-needle aspiration for mediastinal staging. *Eur Respir J* 2005; 25: 416–421.
- 3 Schieppatti E. La puncion mediastinal a traves del espolon traqueal [Trans-tracheal aspiration of the mediastinum]. *Rev As Med Argent* 1949; 663: 497–499.
- 4 Oho K, Kato H, Ogawa I, Hayashi N, Hayata Y. A new needle for transfiberoptic bronchoscope use. *Chest* 1979; 76: 492.
- 5 Rodriguez de Castro F, Diaz Lopez F, Serda GJ, Lopez AR, Gilart JF, Cabrera Navarro P. Relevance of training in transbronchial fine-needle aspiration technique. *Chest* 1997; 111: 103–105.
- 6 Hermens FHW, Van Engelenburg TCA, Visser FJ, Thunnissen FBJM, Termeer R, Janssen JP. Diagnostic yield of transbronchial histology needle aspiration in patients with mediastinal lymph node enlargement. *Respiration* 2003; 70: 631–635.
- 7 Schenk DA, Chambers SI, Derdak S, *et al.* Comparison of the Wang 19 gauge and 2 gauge needles in the mediastinal staging of lung cancer. *Am Rev Respir Dis* 1993; 147: 1251–1258.
- 8 Herth F, Becker HD, Ernst A. Conventional vs endobronchial ultrasound-guided transbronchial needle aspiration: a randomized trial. *Chest* 2004; 125: 322–325.

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From the authors:

We read with interest the letter to the Editors by J. Janssen and coworkers regarding our editorial comment on endoscopic ultrasound-guided fine-needle aspiration biopsy (EUS-FNA), which was featured in the March issue of the *European Respiratory Journal* [1].

Our comment resumes the present status concerning EUS-FNA in the chest [1]. All available studies indicate that EUS-FNA is promising in lung cancer (LC) staging. However, as stated several times in our comment, final conclusions have to await large blinded, randomised comparative studies. So, what do we do in the mean time when dealing with the major cancer-related cause of death with a terrible prognosis, which is almost unchanged during the past 40 yrs?

Concerning the right paratracheal regions (2R+4R), we agree that these regions are not as easily accessible by EUS-FNA when compared with the left-sided mediastinal regions. At present, mediastinoscopy (MS) may be the best method for these regions. According to our experience, an important number of patients with 2–4R disease can be diagnosed with advanced inoperable disease by EUS-FNA [2].

With regards to transbronchial needle aspiration (TBNA) biopsy, we do agree that the results of this minimally invasive method should not be neglected and TBNA should be performed during initial bronchoscopy in patients suspected of LC. Only patients considered as surgical candidates after TBNA should undergo further invasive staging. That is the current practice at our centre and, we suppose, most other centres. However, in spite of TBNA and MS, ~40% of intended curative operations for LC are either explorative without resection or followed by recurrence. This is due to undetected advanced disease prior to surgery. Therefore, new and minimally invasive methods are needed to improve LC staging.

In this context, we found EUS-FNA promising. As EUS-FNA is less invasive, has fewer complications and does not require general anaesthesia, we suggest that EUS-FNA is performed as

the initial invasive staging modality after bronchoscopy plus TBNA.

Since the publication of our editorial comment, two further prospective studies have investigated the addition of EUS-FNA to a standard work-up for unselected LC patients [3, 4]. In one of these studies, the results of EUS-FNA were blinded [3]. The conclusions were clear; EUS-FNA, when added to MS (and TBNA), improves the pre-operative staging of LC, resulting in a reduced rate of futile thoracotomies.

How much additional proof do we need? Should we ask for more evidence from new less invasive methods that exists for the standard methods? When is the right time to change or add to standards? We believe, based on the current literature, that the time has come for EUS-FNA.

However, the aim of our editorial comment was not to claim the superiority of one method above the other, but to inform thoracic specialists that, according to the available evidence, the addition of endoscopic ultrasound-guided fine-needle aspiration to a standard work-up improves selection of surgically curable patients with lung cancer.

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REFERENCES

- 1 Vilmann P, Larsen SS. Endoscopic ultrasound-guided biopsy in the chest: little to lose, much to gain. *Eur Respir J* 2005; 25: 400–401.
- 2 Larsen SS, Vilman P, Krasnik M, *et al.* Endoscopic ultrasound-guided biopsy *versus* mediastinoscopy for analysis of paratracheal and subcarinal lymph nodes in lung cancer staging. *Lung Cancer* 2005; 48: 85–92.
- 3 Annema JT, Versteegh MI, Veselic M, *et al.* Endoscopic ultrasound added to mediastinoscopy for preoperative staging of patients with lung cancer. *JAMA* 2005; 294: 931–936.
- 4 Larsen SS, Vilman P, Krasnik M, *et al.* Endoscopic ultrasound guided biopsy performed routinely in lung cancer staging spares futile thoracotomies: preliminary results from a randomised clinical trial. *Lung Cancer* 2005; 49: 377–385.

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Projections of COPD in males in the Netherlands

To the Editors:

In a recent issue of the *European Respiratory Journal*, projections for a large increase in chronic obstructive pulmonary disease (COPD) in females in the Netherlands up to 2025 were recorded in the study by HOOGENDOORN *et al.* [1]. These are depressing, but expected given recent observed trends and the modest changes in smoking made by Dutch females since 1980 [2, 3]. However, males in the Netherlands, who had the highest known usage of tobacco products per adult of any country from the 1930s to the 1950s [2], have considerably reduced their cigarette consumption since the 1970s [2, 3]. Therefore, it is disconcerting to see that continuing upward trends in COPD, albeit smaller in scale, are also projected for Dutch males. Where the predicted time trend is shown [1], there is little, if any, slowing of the rate of increase over the whole period up to 2025. In contrast, according to the World Health Organization (WHO) compilation of national statistics presented by PETO *et al.* [4], total deaths from lung cancer have recently begun to fall in males within the European Union. In the Netherlands, total male deaths from lung cancer and rates per 100,000 in both the total adult population, and those aged 75–79 yrs, all declined progressively between 1985 and 2000. As discussed in the accompanying editorial by MANNINO [5], and elsewhere [6], slower and less dramatic benefits would be expected in COPD than in lung cancer after quitting smoking. Nevertheless, WHO data on COPD mortality in the Netherlands [4] also indicate that between 1990 and 2000 total male deaths have been stable, whereas death rates per 100,000 for the total adult population, and for males aged 75–79 yrs, have both declined by a similar proportionate amount.

While recognising that the primary purpose of the authors' model is to estimate total future costs due to chronic obstructive pulmonary disease, regardless of how these costs arise, the authors hardly comment on the extent to which their estimates depend on demographic changes, in particular, increased age of the population (which perhaps represents medical "success" but increases costs and worries pension funds) and how much depends on the persistence of smoking-related disease (which is amenable to preventive medicine). The increases presented for prevalence and mortality could potentially be explained entirely by population ageing, but there is no quantification of these two major factors to support or refute this possibility. Such information might help the medical reader to better understand the paradox that, while smoking is the most important aetiological factor for causing physician-diagnosed chronic obstructive pulmonary disease, its prevalence and mortality can be projected to continue to increase even after 45 yrs of reduction in cigarette smoking by Dutch males.

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REFERENCES

- 1 Hoogendoorn M, Rutten-van Molken MPMH, Hoogenveen RT, *et al.* A dynamic population model of disease progression in COPD. *Eur Respir J* 2005; 26: 223–233.
- 2 Forey B, Hamling J, Lee P, Wald N. International Smoking Statistics. A Collection of Historical Data from 30 Economically Developed Countries. 2nd Edn. Wolfson