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Value of imprint cytology for ultrasound-guided transthoracic core biopsy

To the Editors:

LIAO *et al.* [1] have shown that imprint cytology of ultrasound-guided transthoracic core biopsy is a sensitive procedure for diagnosing peripheral thoracic lesions. Similarly, we have recently reported the results of our experience of using touch imprint smears prepared from computerised tomographic-guided core needle lung biopsies [2]. We correlated the cytological diagnosis of touch imprint smears with the histological diagnosis of the corresponding core needle-biopsy specimen, which was taken as the gold standard. There were no false-positive results, and all patients with small cell lung cancer were correctly diagnosed from the imprint smear. We agree that the technique is a quick, sensitive and highly specific method of detecting lung malignancies, and this may be particularly important with small cell lung cancer, where one

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may wish to start urgent chemotherapy pending the result of formal histology.

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Flow limitation and dynamic hyperinflation

To the Editors:

In the January issue of the *European Respiratory Journal*, in a very well-written paper, CALVERLEY and KOULOURIS [1] comprehensively reviewed the concepts of expiratory flow limitation and dynamic hyperinflation, and assessed their potential importance in pulmonary disease.

They underlined the fact that, in nonintrathoracic airflow-limited snorers or obstructive sleep apnoea-hypopnoea syndrome (OSAHS) patients, the higher collapsible upper airway could promote an expiratory flow limitation.

Our group recently published data on the operating characteristics of the negative expiratory pressure (NEP) technique in the prediction of OSAHS in 238 snoring patients free of pulmonary and cardiac disease [2].

The findings of the study were that in the supine position: 1) the degree of instability of the upper airway measured by the NEP was correlated with the severity of OSAHS; and 2) using an expiratory flow-limitation cut-off of 27.5% of the tidal volume, NEP had moderate sensitivity (81.9%) and specificity (69.1%) in the prediction of OSAHS, defined as an apnoea-hypopnoea index $\geq 15 \cdot h^{-1}$.

It should be noted that, in agreement with TANTUCCI *et al.* [3], we found that only 44% of the subjects with primary snoring

(OSAHS $< 5 \cdot h^{-1}$) did not exhibit an expiratory flow limitation when the NEP was applied, and 23% demonstrated an expiratory flow limitation $\geq 27.5\%$ of the tidal volume.

Although further studies need to confirm these results, negative expiratory pressure may be a diagnostic tool in the work-up of obstructive sleep apnoea-hypopnoea syndrome.

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