

CORRESPONDENCE

Survey of flexible fiberoptic bronchoscopy in the UK

To the Editor:

The survey of flexible fiberoptic bronchoscopy in the United Kingdom by SMYTH and STEAD [1] was based on a questionnaire and is therefore completely reliant on the memories of physicians who have carried out bronchoscopies. Unfortunately, it quotes guidelines that are out of date and indeed does not reference the latest British Thoracic Society guidelines which were published 9 months before the paper was accepted for publication [2]. The survey had a modest response rate of 60%, but nevertheless there were some interesting results.

Many practices are not in keeping with the latest British Thoracic Society guidelines. For instance many patients were fasted for longer than the recommended 4 h before the procedure [3]. There was unnecessary checking of blood clotting measurements by 18% of respondents and 29% used an antimuscarinic agent despite good evidence that this is unnecessary [4]. The authors of the survey imply that electrocardiogram (ECG) and blood pressure monitoring during the procedure should be carried out, but unless there is evidence of unstable cardiovascular disease there is no evidence that this is indicated routinely. The survey did highlight the need to improve the use of protective equipment worn by staff during the procedure, as has been reported previously [5].

At least two published studies have shown that the risk of pneumothorax following transbronchial biopsy without fluoroscopy for diffuse lung disease such as sarcoidosis is low (3.5% in one large study [6]). About 50% of patients with a pneumothorax after transbronchial biopsy required drainage [7]. Another published study showed no increased risk of pneumothorax in patients with suspected sarcoidosis undergoing transbronchial lung biopsy without fluoroscopy compared to those with fluoroscopy [8]. One of the problems with postal questionnaires is that it may not be possible for respondents to remember whether transbronchial biopsies were being carried out for diffuse or localised peripheral lung lesions. There are, however, obvious potential advantages of fluoroscopy when carrying out transbronchial biopsies in patients with localised lesions, but many centres now use a trans-thoracic needle biopsy performed with computed tomography scanning. The conclusion from this survey, that the use of radiographic screening during transbronchial lung biopsy is associated with a lower

risk of pneumothorax requiring chest tube drainage, is suspect.

It was disappointing to see that over one third of respondents did not routinely obtain biopsies, washings and brushings when a visible tumour was present, as use of all three has been shown to improve the diagnostic rate [9]. This survey has however highlighted areas that need improvement based upon evidence-based guidelines such as those recently published.

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