



CORRESPONDENCE

Therapeutic bronchoscopy with immediate effect revisited: “tissue is the issue”

To the Editors:

In the paper by BOLLIGER *et al.* [1], the authors highlight that there have been very few multicentre trials and no randomised prospective trials on interventional stent insertion. They write that different centres have different levels of expertise at interventional bronchoscopy. With that in mind, the idea of management guidelines for treatment must surely be appealing, so that we all have a standard approach to treatment and diminish variability across centres.

This point was highlighted by a recent case at our unit. An elderly frail patient presented in respiratory failure with stridor, haemoptysis and weight loss. She had been a lifelong smoker, had a history of cardiac disease and a World Health Organization (WHO) performance status of 2. A computerised tomography scan of the thorax revealed a tumour-like mass in the trachea consistent with tracheal malignancy. Despite her deteriorating condition, bronchoscopy was performed which indeed confirmed a friable tumour-like mass causing severe tracheal stenosis. Laser therapy was administered. Biopsies were taken and complicated by significant haemoptysis. The histology report was inconclusive.

As the patient was extremely unwell and because there is wide variability across centres without set guidelines for interventional bronchoscopy, the next step was to be quite tricky. The patient's history and investigative findings directed us to a clinical diagnosis of probable inoperable tracheal malignancy. Following a multidisciplinary team meeting and family discussion explaining the risks of further interventional therapy, we listed the patient for another bronchoscopy with further biopsies and stent insertion if the proceedings progressed satisfactorily. We performed the bronchoscopy and biopsies with great care and duly inserted an endotracheal stent.

To our amazement, within 5 days the patient was mobilising with normal oxygen saturations and with resolution of the stridor and haemoptysis. The histology of the biopsies revealed

a surprising diagnosis of the extremely rare and benign tracheobronchial amyloidosis. The patient remains well and attends regular assessment and follow-up sessions.

We believe this case highlights two points. First, that even if the signs, symptoms and investigations strongly point towards malignancy, “tissue is the issue”. Histology is still required even in elderly frail hypoxic patients, and maximum consideration and careful assessment should be made to ascertain whether or not this can be obtained safely rather than assuming that the diagnosis is malignant, requiring palliation. Secondly, we appreciate that there is variability between centres, ranging from conservative treatment to aggressive intervention, and believe that this patient's treatment may have been different in other centres, with a potentially worse outcome. Guidelines resulting from randomised prospective trials (if undertaken) may make it easier for centres to make these difficult decisions. If and when these guidelines arrive, would we still treat the patient in the same manner? If not, then in those very few patients, a rare but treatable benign condition of the tracheobronchial tree may be their downfall!

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STATEMENT OF INTEREST

None declared.

REFERENCES

- 1 Bolliger CT, Sutudja TG, Strausz J, Freitag L. Therapeutic bronchoscopy with immediate effect: laser, electrocautery, argon plasma coagulation and stents. *Eur Respir J* 2006; 27: 1258–1271.

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