

- 4 Troosters T, Gosselink R, Decramer M. Six minute walking distance in healthy elderly subjects. *Eur Respir J* 1999; 14: 270–274.
- 5 Gibbons WJ, Fruchter N, Sloan S, Levy RD. Reference values for a multiple repetition 6 minute walk test in healthy adults older than 20 year. *J Cardiopulm Rehabil* 2001; 21: 87–93.

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From the authors:

I. García-Talavera's reaction to the results of our trial of ambulatory oxygen (AO) in oxygen-dependent chronic obstructive pulmonary disease (COPD) is of no surprise to us. We realise that our findings, *i.e.* that as-needed AO provided for a period of 3 months had no effect on quality of life and walked distance [1], are against the stream of current guidelines (*i.e.* that active patients receiving long-term oxygen therapy should have both stationary and mobile systems of oxygen delivery) [2, 3].

Negative trials are often inconclusive because of imprecise estimates of treatment effects that leave uncertainty about their conclusions [4]. However, the width of the observed confidence intervals around the mean responses, and their relation to the respective minimal clinically important differences, are clear indications that the sample size of our trial does not explain its negative results. Should we repeat this experiment in 100 different samples of patients with oxygen-dependent COPD, we would find 95 times that the treatment effect of AO is smaller than what is usually considered clinically significant [5]. This is evidence-based medicine.

Other issues raised by I. García-Talavera relate to the variations of oxygen saturation during the 6-minute walk test and the mean arterial oxygen tension (P_{a,O_2}) of our patients. We studied patients with oxygen-dependent COPD. The mean P_{a,O_2} (7.0 kPa (53 mmHg); SD: 4) is a reflection of the trial inclusion criteria. All were desaturated during the baseline, and walk test was performed while breathing room air (mean nadir: 83%; SD: 5). AO was titrated to maintain a saturation $\geq 90\%$ during ambulation. It is our experience that patients with more severe hypoxaemia have more advanced disease and are more often house-bound. Whether the results of a similar trial would be different in patients with more severe

hypoxaemia is possible but, in our opinion, unlikely. This remains to be seen.

We do not negate that a small proportion of patients with oxygen-dependent chronic obstructive pulmonary disease could really benefit from ambulatory oxygen. Our challenge is to identify these patients. Unfortunately, acute response to ambulatory oxygen does not predict long-term improvement in quality of life in patients with chronic obstructive pulmonary disease not fulfilling criteria for long-term oxygen therapy, but with exertional desaturation [5, 6]. We came to the same conclusion in oxygen-dependent chronic obstructive pulmonary disease following secondary (and as yet unpublished) analyses of our data.

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REFERENCES

- 1 Lacasse Y, Lecours R, Pelletier C, Bégin R, Maltais F. Randomised trial of ambulatory oxygen in oxygen-dependent COPD. *Eur Respir J* 2005; 25: 1032–1038.
- 2 Celli BR, MacNee W, ATS/ERS Task Force. Standards for the diagnosis and treatment of patients with COPD: a summary of the ATS/ERS position paper. *Eur Respir J* 2004; 23: 932–946.
- 3 National Collaboration Centre for Chronic Conditions. Chronic obstructive pulmonary disease: national clinical guideline for management of chronic obstructive pulmonary disease in adults in primary and secondary care. *Thorax* 2004; 59: Suppl. 1, 1–232.
- 4 Detsky AS, Sackett DL. When was a "negative" clinical trial big enough? How many patients you needed depends on what you found. *Arch Intern Med* 1985; 145: 709–712.
- 5 Man-Son-Hing M, Laupacis A, O'Rourke K, *et al.* Determination of the clinical importance of study results: a review. *J Gen Intern Med* 2002; 17: 469–476.
- 6 Eaton T, Garrett JE, Young P, *et al.* Ambulatory oxygen improves quality of life of COPD patients: a randomised controlled study. *Eur Respir J* 2002; 20: 306–312.

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Cystic lesions of the lung: a forgotten menace

To the Editors:

We read with interest the article by BATTISTINI *et al.* [1] concerning a young female with spontaneous pneumothorax as the presenting feature of pulmonary lymphangiomyoma, which appeared in a previous issue of the *European Respiratory Journal*. The differential diagnoses, which included lymphangiomyoma, tuberous sclerosis and Langerhans cell

histiocytosis or eosinophilic granuloma, were based on bilateral cystic pulmonary lesions on high-resolution computed tomography, which were slow to progress, as well as the relatively normal pulmonary function tests [2].

We recall a 46-yr-old male who presented to us with left spontaneous pneumothorax, followed 2 days later by the development of contralateral pneumothorax. A computed

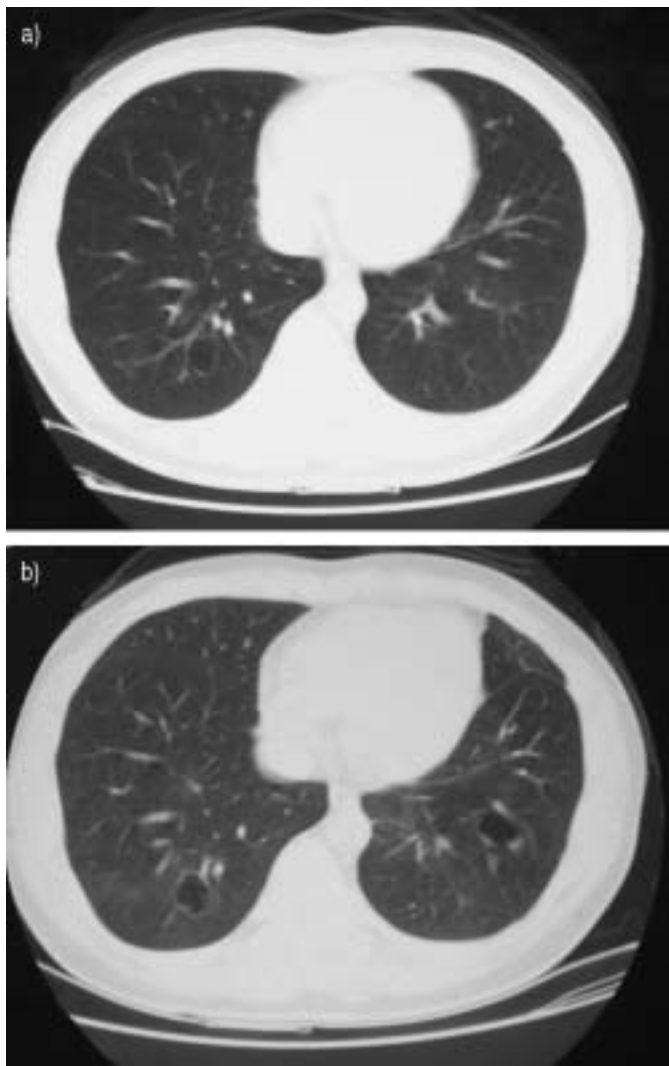


FIGURE 1. Computed tomography scan of the patient showing: a) an emerging thin-walled cystic lesion in the right lower lobe; and b) a slight increase in size of the original right lesion and a new development in the contralateral side at 2-yr follow-up.

tomography scan revealed bilateral multiple cystic lesions with thin smooth walls of varying sizes. However, the male sex prompted us to exclude a more sinister cause for the lesions

[2], and upon further questioning the patient had complained of right thigh pain for several weeks. Examination revealed a fixed soft tissue mass in the mid-thigh. Histology from the thigh mass biopsy and bilateral video-assisted thoracic surgery bullectomy [3] confirmed pulmonary epithelioid sarcoma metastases. Subsequent investigations showed no other organ was involved. The pulmonary lesions progressed over a 5-yr period, eventually leading to respiratory failure.

Pulmonary cysts as the sole metastatic manifestation of sarcomas are rare, with <20 cases reported [4]. The cysts are usually thin walled, without debris and slow growing (fig. 1).

Typically, the cystic lesions are not evident on chest radiographs, but are well visualised on computed tomography scans, where they may mimic benign bullous disease. The diagnosis may not be established until patients present with pneumothorax necessitating surgical intervention and biopsy [3, 5].

Clinicians should be aware of this important differential diagnosis of bilateral pulmonary cystic lesions, and exclude metastatic sarcoma in the assessment of their patients.

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REFERENCES

- 1 Battistini E, Gambini C, Rossi UG, *et al.* Spontaneous pneumothorax in a 24-year-old female. *Eur Respir J* 2005; 25: 575–580.
- 2 Johnson SR, Whale CI, Hubbard RB, Lewis SA, Tattersfield AE. Survival and disease progression in UK patients with lymphangioleiomyomatosis. *Thorax* 2004; 59: 800–803.
- 3 Yim APC, Ng CSH. Thoracoscopic management of spontaneous pneumothorax. *Curr Opin Pulm Med* 2001; 7: 210–214.
- 4 Hasegawa S, Inui K, Kamakari K, Kotoura Y, Suzuki K, Fukumoto M. Pulmonary cysts as the sole metastatic manifestation of soft tissue sarcoma. *Chest* 1999; 116: 263–265.
- 5 Traweek T, Rotter AJ, Swartz W, Azumi N. Cystic pulmonary metastatic sarcoma. *Cancer* 1990; 65: 1805–1811.

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Nontraumatic chylothorax and previous cancer: a role for positron emission tomography?

To the Editors:

Nontraumatic chylothorax in the adult is suggestive of a tumour, mainly lymphoma and metastatic carcinoma,

particularly when prior neoplasm is diagnosed. If radiological procedures reveal no mediastinal lesion, surgical exploration may be suggested. Conversely, a tumour might become evident even 6–12 months after the appearance of chylothorax