Form the authors:

We thank G.L. Casoni and V. Poletti for their comments regarding our study showing the diagnostic utility of a thin bronchoscope with a 1.7-mm working channel for peripheral pulmonary lesions [1]. Their main quarrel with a channel of this size is its possible inability to control bleeding, and they argue that larger forceps are better than smaller ones in terms of diagnostic yield.

Bleeding is one of the well-known and potentially serious complications associated with transbronchial biopsy (TBB). We think that the risk of severe bleeding associated with thin bronchoscopy is lower than with conventional bronchoscopy. Biopsy with small forceps is likely to reduce the risk of a massive haemorrhage. Additionally, the technique, in which the tip of the thin bronchoscope is wedged firmly into the peripheral bronchi during TBB, may also contribute to the reduction of bleeding complications. Of course, the safety of the procedure was one of the key points in the evaluations in our study, and no significant bleeding which could not be controlled by the thin bronchoscope was observed. We think this procedure is indeed safe on the basis of the results.

The second issue raised is controversial, whether or not the size of the biopsy forceps influences the diagnostic yield [2, 3]. The British Thoracic Society Bronchoscopy Guidelines Committee [4] noted that ''the type of forceps used does not seem to influence the diagnostic yield.'' Although the results of the published studies concerning the relationship between the diagnostic yield and the size of forceps might not be applicable to the small forceps for a 1.7-mm working channel, several studies [5, 6] using these forceps, including ours, have demonstrated field-proven results in terms of diagnostic yield.

We agree that endobronchial ultrasound is a useful adjunct to bronchoscopy. Other new modalities such as electromagnetic navigation, virtual bronchoscopic navigation or computed tomography fluoroscopy should also be useful as well as thin bronchoscopy. These new modalities seem to offer improved diagnostic yield compared with conventional bronchoscopy, although none of them may be optimal. In any case, we bronchoscopists must not be content with the ''best approach,'' which is only the best approach so far. There is indeed a better way to diagnose peripheral pulmonary lesions; we simply must find it.

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STATEMENT OF INTEREST

None declared.

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Familial spontaneous pneumothorax: importance of screening for renal tumours

To the Editors:

We read with interest the recent article by FRÖHLICH *et al.* [1], wherein the authors reported two new disease-associated DNA sequence alterations in *FLCN*, the tumour suppressor gene located at chromosome 17p11.2 which, when mutated, leads to the genodermatosis Birt–Hogg–Dubé syndrome (BHDS). However, we feel that there is an important point that deserves greater prominence.

BHDS was named after three Canadian dermatologists who, in 1977, described 15 adults in a kindred of 70 who had multiple small, dome-shaped papular skin lesions, presenting at >25 yrs of age, over the scalp, forehead, face and neck, with scattered lesions on the chest and back [2]. Histologically, these lesions were confirmed to be fibrofolliculomas, benign hamartomas of the hair follicle. Subsequently, this syndrome was found to be a marker of internal disease, as cases of recurrent pneumothorax, lung cysts [3] and renal tumours [3, 4] were reported.

BHDS has now been recognised as one of the inherited renal cancer syndromes, which include von Hippel Lindau, hereditary papillary renal carcinoma and hereditary leiomyomatosis renal cell carcinoma [5]. Renal tumours have been reported in as many as 34% of individuals with germline *FLCN* mutations [6].