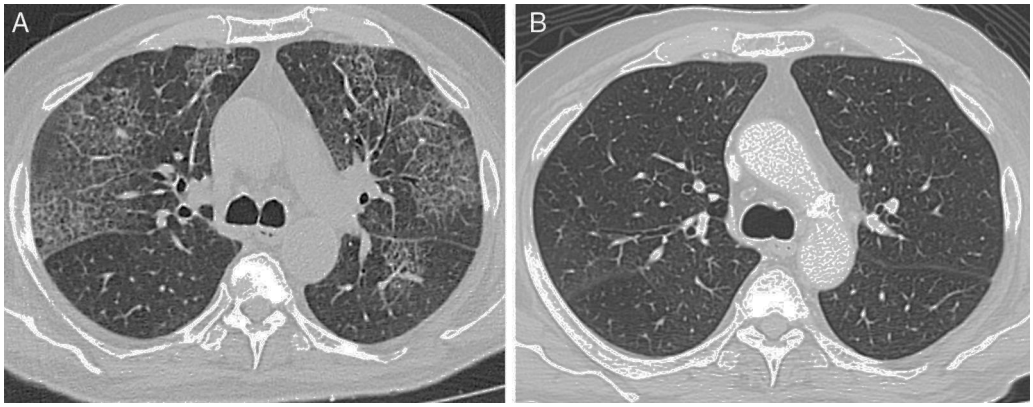

Fig. 1. (A) Chest high-resolution computed tomography showing bilateral ground glass opacities and interlobular septal thickening. (B) Chest high-resolution computed tomography after corticosteroid treatment, showing resolution of the pulmonary lesions.

choice is systemic corticosteroids.[2] Our patient presented clinical and radiological findings consistent with radiation pneumonitis. It is important that this complication is recognized, and it must be taken into account among patients undergoing hepatic radioembolization.

References

1. Memon K, Lewandowski R, Kulik L. Radioembolization for primary and metastatic liver cancer. Semin Radiat Oncol. 2011;21:294–302.
2. Leung T, Lau W, Ho S. Radiation pneumonitis after selective internal radiation treatment with intraarterial 90 yttrium-microspheres for inoperable hepatic tumors. Int J Radiat Oncol Biol Phys. 1995;33:919–24.
3. Salem R, Parikh P, Atassi B, Lewandowski RJ, Ryu RK, Sato KT, et al. Incidence of radiation pneumonitis after hepatic intra-arterial radiotherapy with yttrium-90 microspheres assuming uniform lung distribution. Am J Clin Oncol. 2008;31:431–8.
4. Riaz A, Awais R, Salem R. Side effects of yttrium-90 radioembolization. Front Oncol. 2014;4:198.
5. Mosconi C, Cappelli A, Pettinato C, Golfieri R. Radioembolization with Yttrium-90 microspheres in hepatocellular carcinoma: role and perspectives. World J Hepatol. 2015;7:738–52.

Horacio Matías Castro,* Esteban Javier Wainstein, Joaquin Maritano Furcada

Departamento de Medicina Respiratoria, Hospital Italiano de Buenos Aires, Buenos Aires, Argentina

* Corresponding author.
E-mail address: matias.castro@hospitalitaliano.org.ar (H.M. Castro).

1579-2129/

Dogmas and Medical Beliefs in COPD☆

Dogmas y Creencias Médicas Acerca de la EPOC

To the Editor,

Physicians who spend their lives treating patients have always lived with the social representations of health, disease, and medication. These social representations are construct images of a natural reality and are as old as the disease itself. Based on affective and cognitive predispositions, and often inhabited by fears, beliefs, and magical and supernatural elements, the function of social representations is to make something unusual and unknown familiar to the patient.

Chronic obstructive pulmonary disease (COPD) and inhaled medications do not escape these social representation systems. The theory of social representations was first formulated by social psychologist Serge Moscovici in a paper published in France in 1961.[1] I wonder, however, if COPD is not itself also represented in doctors who usually treat this complex disease in hospitals or in primary health care, and if their representation is haunted by dogmas and medical beliefs.

In COPD, as in many other chronic diseases, non-adherence to medication is a critical issue.[2] Non-adherence to inhaled therapy in COPD has been called a high magnitude problem and a major factor of therapeutic failure, but only a limited number of studies have specifically examined adherence in patients with COPD therapy, and most research was conducted before the widespread availability of inhaled medications taken once or twice daily. In some original articles, many patient characteristics, such as the degree of bronchial obstruction or symptoms like dyspnea, are missing. However, it is well known that dyspnea, fear of dyspnea, and feelings of vulnerability contribute to better adherence to medication. Poor adherence to therapy, therefore, does not seem to make much sense from a clinical point of view, especially in these very symptomatic patients with COPD Gold stage B or D. Poor medication adherence in COPD has become a dogma that may well not correspond to reality, at least in patients with greater severity, and as such remains an open issue that merits further investigation.[3]

Another persistent dogma is the belief that once-daily medication is the best alternative for all COPD patients,[4] because it is easier to use and improves compliance. As effort dyspnea is the main symptom of COPD, the most commonly recommended schedule for bronchodilator therapy administration is early morning. Many patients, however, experience an evening aggravation or at least a fear of a nocturnal aggravation of dyspnea. Patients use inhalers because they feel relief from their dyspnea. As therapy in COPD is to some extent driven by symptoms, a twice-daily bronchodilator regimen may be more suitable in certain patient groups, such as those with exacerbating phenotypes or asthma-COPD overlap syndrome (ACOS).

☆ Please cite this article as: Araújo AD. Dogmas y creencias médicas acerca de la EPOC. Arch Bronconeumol. 2017;53:217–218.

The introduction of inhaled corticosteroids (ICs) to COPD therapy has been widely debated in medical and scientific communities. Weaning from ICs in COPD, and 4 other important randomized trials that evaluated the effect of IC discontinuity (COPE, COSMIC, INSTEAD, and WISDOM), have also created considerable controversy.[5] However, ICs in association bronchodilators have long been a mainstay of treatment for COPD. It was only the recent introduction of new long-acting bronchodilators, specifically developed for the treatment of COPD, and new fixed combinations of LABA-LAMA that led to the current debate in the medical community.[6] There is now enough clinical evidence to challenge the widespread use of IC in COPD in patients who do not suffer from exacerbations and who have not shown any benefit with ICs.[7]

The science of medicine is characterized by its evidence-based approach and its revisibility. As a human activity, it is necessarily subject to dogmas and beliefs. Whether it was the medical representation of COPD as an inflammatory disease or the medical belief of a real benefit to the patient that led to the widespread use of ICs in COPD is still unclear. However, the medical community must wonder how real-life patients in real-life situations are represented in large randomized studies (often double-blind, placebo-controlled trials) supporting evidence-based medicine.

Conflicts of Interest

The author has no conflicts of interest to declare.

References

1. Sevalho G. Uma Abordagem Histórica das Representações Sociais da Saúde e Doença. Cadernos de Saúde Pública, 9. Río de Janeiro: Escola Nacional de Saúde Pública; 1993. p. 49–363.
2. Sommariva S, Finch A, Jommi C. The assessment of new drugs for asthma and COPD: a Delphi study examining the perspectives of Italian payers and clinicians. Multidiscip Respir Med. 2016;11:4.
3. Celli B, Decramer M, Wedzicha J, Wilson K, Agusti A, Criner J, et al., ATS/ERS task force for COPD research. An official American Respiratory Society/European Respiratory Society statement: research questions in COPD. Eur Respir J. 2015;45:879–905.
4. Agusti A, Vestbo J. Current controversies future perspectives in chronic obstructive pulmonary disease. Am J Respir Crit Care Med. 2011;184:507–13.
5. Suissa S, Rossi A. Weaning from inhaled corticosteroids in COPD: the evidence. Eur Respir J. 2015;46:1232–5.
6. Agusti A. Inhaled steroids in COPD: reasons for a debate. Rev Port Pneumol. 2015;21:175–7.
7. Miravitlles M. Towards a patient-oriented treatment of COPD. Rev Port Pneumol. 2016;22:73–4.

António Duarte Araújo[a,b]

[a] *Respiratory Department, Hospital Senhora da Oliveira, Guimarães, Portugal*
[b] *Life and Health Sciences Research Institute (ICVS), University of Minho, Portugal*
E-mail address: duartearaujodr@sapo.pt

1579-2129/

The Co-occurrence of Bronchial Anthracofibrosis and Interstitial Lung Disease☆

Antracofibrosis bronquial y enfermedad pulmonar intersticial simultáneas

To the Editor:

The term 'bronchial anthracofibrosis' (BAF) was enunciated by Chung et al.[1] from Korea, when they described bronchoscopically visible anthracotic pigmentation and narrowing/obliteration of bronchi in 28 elderly patients with significant exposure to wood smoke. The mucosal pigmentation is characteristically seen around the branching point.

Increasing awareness of this disease has led to the clinical, radiological and bronchoscopic characterisation of BAF, and its strong association with tuberculosis, pneumonia, chronic obstructive pulmonary disease and lung cancer have been highlighted.[2] However, the association of BAF with interstitial lung disease (ILD) has rarely been documented. Only two reports in four patients have been published,[3,4] with only one report detailing the co-occurrence of usual interstitial pneumonia (UIP) pattern with BAF.[5] The rarity of such a description in the literature prompted us to report 2 female patients who underwent diagnostic fiberbronchoscopy (FOB) for

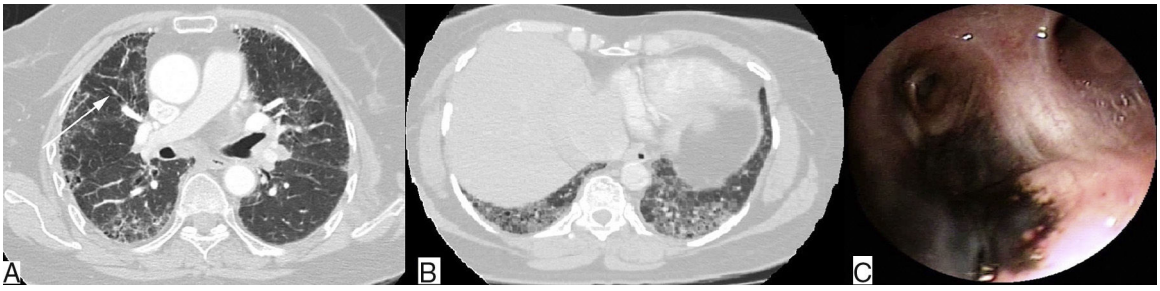

Fig. 1. (A) High resolution computed tomography (HRCT) of the thorax [lung window] showing interlobular septal thickening along with ground glass opacities and traction bronchiectasis in a sub-pleural distribution with multifocal narrowing of the right upper lobe bronchus (white arrow). (B) Chest high resolution computed tomography (HRCT) (lung window) showing interlobular septal thickening along with honeycombing in a basilar and sub-pleural distribution suggestive of UIP pattern. (C) Fiberbronchoscopic image showing anthracotic pigmentation of bronchial mucosa with narrowing and distortion of the apical segment of right upper lobe bronchus.

☆ Please cite this article as: Kunal S, Pilaniya V, Shah A. Antracofibrosis bronquial y enfermedad pulmonar intersticial simultáneas. Arch Bronconeumol. 2017;53:218–219.