complications. Most localized adverse effects are generally self-limiting, and include hematuria, dysuria, cystitis, prostatitis, and orchitis. Systemic adverse effects, however, are less common, and can range from simple febricula to potentially fatal multi-organ failure.[2]

Several cases of pulmonary or extra-pulmonary granulomatous lymphadenitis secondary to BCG instillation have been described in the English-language literature. However, there is considerable debate on whether the infectious complications secondary to BCG are due to a hypersensitivity reaction or to active infection. Some studies have found viable bacteria in different tissues, such as the lung, pancreas and liver, suggesting active infection.[3,4] The hypersensitivity hypothesis, meanwhile, is supported by studies in which microorganisms could not be isolated.[5] This was the case in our patient, as we were unable to demonstrate the presence of acid-fast bacilli in 3 sputum samples and 1 bronchoalveolar lavage sample; culture results were also negative.

In summary, this case is of interest insofar as it illustrates a characteristic complication of intravesical BCG instillation. We hope this report will highlight the importance of bearing in mind the different complications of intravesical BCG treatment, even when there is clinical suspicion of BCG infection.

Conflict of interests

The authors have no conflict of interests or funding to declare.

References

1. Hall MC, Chang SS, Dalbagni G, Pruthi RS, Seigne JD, Skinner EC, et al. Guideline for the management of nonmuscle invasive bladder cancer (stages Ta, T1, and Tis): 2007 update. J Urol. 2007;178:2314–30.
2. Park CH, Jang MA, Ahn YH, Hwang YY, Ki CS, Lee NY. Mycobacterial infection after intravesical bacillus Calmette–Guérin treatment for bladder cancer: a case report. Korean J Lab Med. 2011;31:197–200.
3. McParland C, Cotton DJ, Gowda KS, Hoeppner VH, Martin WT, Weckworth PF. Miliary *Mycobacterium bovis* induced by intravesical bacille Calmette–Guérin immunotherapy. Am Rev Respir Dis. 1992;146:1330–3.
4. Soylu A, Ince AT, Polat H, Yasar N, Ciltas A, Ozkara S, et al. Peritoneal tuberculosis and granulomatous hepatitis secondary to treatment of bladder cancer with bacillus Calmette–Guérin. Ann Clin Microbiol Antimicrob. 2009;8:12.
5. Elkabani M, Greene JN, Vincent AL, VanHook S, Sandin RL. Disseminated *Mycobacterium bovis* after intravesicular bacillus Calmette–Guérin treatments for bladder cancer. Cancer Control. 2000;7:476–81.

Deniz Dogan,[a] Murat Zor,[a,*] Tuncer Ozkisa,[a] Omer Ayten,[b] Nuri Yigit,[c] Ismail Savas[d]

[a] *Department of Pulmonary Diseases, Gulhane Military Hospital, Ankara, Turkey*
[b] *Department of Pulmonary Diseases, Gulhane Military Hospital, Istanbul, Turkey*
[c] *Department of Pathology, Gulhane Military Hospital, Ankara, Turkey*
[d] *Department of Pulmonary Diseases, Ankara University Medical Faculty, Ankara, Turkey*

* Corresponding author.
E-mail address: murat804@yahoo.com (M. Zor).

Spirometry in Public Hospitals in Navarre. A Comparative Analysis of the 3E Study☆

La espirometría en la Neumología pública en Navarra. Análisis contrastado del estudio 3E

To the Editor,

We read with interest the study published in the November issue of your journal by Drs López-Campos, Soriano, and Calle,[1] addressing inter-regional differences in the conduct and interpretation of spirometries in Spain. The methods section states that the data were obtained from a telephone survey of 805 centers selected randomly from among those routinely assessing adult patients with chronic respiratory disease. The survey was completed by the technician responsible for performing spirometries in each center. We are unaware of how applicable the results may be in other regions, but we would like to point out some discrepancies between the survey results and the data available in our own setting. Indeed, there are stark differences between the authors' claims and the results of an assessment of spirometry testing in primary care (PC) in our setting that we published in your journal in 2006.[2] However, we are even more concerned by their results on spirometry conducted in specialized centers (SC) in 2012 (the year the study was carried out).

In Table 1, we have listed some of the most striking claims made in this article, and compared them with data from all public respiratory medicine departments in Navarre (listed in total, and separately for each of the 3 groups active at that time: Hospital Virgen del Camino, Hospital de Navarra, and Hospital de Estella). It is clear from these data that the results offered in the article of reference do not represent in any way the real situation in our community.

As the criteria for qualifying the bronchodilator test and spirometry quality are not explained in the methods section, we cannot compare them with our own data. In any case, the percentages listed (25% in PC vs 12.5% in SC in the first case and 93.5% vs 37.5% in the second) are surprising to say the least. We cannot be sure that they do not reflect procedures conducted in another type of health system, since the type of centers interviewed (public, private, hospital or clinic) is not specified, nor is the specialty that was evaluated (respiratory medicine, internal medicine, allergology, etc.). However, as the authors describe the situation in SC, we believe it is essential to point out that these figures are a poor reflection of the spirometry activities conducted in the public respiratory medicine departments of our region.

Finally, as the authors themselves admit, although telephone surveys enable researchers to reach a large number of centers, the limitations of this type of approach mean that any conclusions must be viewed with caution.

☆ Please cite this article as: Rivas PC, de Heredia JHP. La espirometría en la Neumología pública en Navarra. Análisis contrastado del estudio 3E. Arch Bronconeumol. 2015;51:527–528.

Table 1
Comparisons Between the Data for Navarre Published in the Article[1] and Those Available in Public Respiratory Medicine Departments in 2012.

Parameter	Data Published for Navarre		Data From All Public Respiratory Medicine Departments in Navarre (2012)			
	PC	SC	Total RMD	RMD HVC	RMD HdN	RMD Estella
Participating centers						
Participating in the survey	16 (80)	8 (80)	2	1	0	1
Total centers contacted	20	10	2	1	0	1
Center resources						
Spirometer in center	1.06	1.88	2.6	4	3	1
Spirometries performed weekly	2.6	63.3	90	125	95	50
Centers with specific timetable (%)	12 (75.0)	6 (75)	(100)	(100)	(100)	(100)
Centers with specific room (%)	8 (50.0)	7 (87.5)	(100)	(100)	(100)	(100)
Training in centers						
Regular training in technique (%)	2 (12.5)	0 (0)	(80)	(100)	(100)	(20)
Use of spirometer						
Information given to patient (%)	15 (93.8)	5 (62.5)	(100)	(100)	(100)	(100)
Information on bronchodilator test						
Appropriate criteria for positivity (%)	5 (31.2)	5 (62.5)	(100)	(100)	(100)	(100)
Information on type of spirometer						
Pneumotachometer transducer (%)	2 (12.5)	2 (25)	8 (100)	4 (100)	3 (100)	1 (100)
Turbine transducer (%)	1 (6.2)	1 (12.5)	(0)	(0)	(0)	(0)
Unknown transducer (%)	13 (81.2)	4 (50)	(0)	(0)	(0)	(0)
Curves only on screen not on paper (%)	15 (93.8)	7 (87.5)	(100)	(100)	(100)	(100)
Reference values unknown (%)	15 (93.8)	3 (37.5)	(0)	(0)	(0)	(0)
Spirometer maintenance and quality criteria						
Maintenance staff (%)	11 (68.8)	4 (50%)	(100)	(100)	(100)	(100)

Estella, Hospital de Estella; HdN, Hospital de Navarra; HVC, Hospital Virgen del Camino; PC, primary care; RMD, respiratory medicine department; SC, specialized centers.

References

1. López-Campos JL, Soriano J, Calle M. Cambios interregionales en la realización e interpretación de las espirometrías en España. Arch Bronconeumol. 2014;50:475–83.
2. Hueto J, Cebollero P, Pascal I, Cascante JA, Eguía VM, Teruel F, et al. Espirometría en Atención Primaria en Navarra. Arch Bronconeumol. 2006;42:326–31.

Pilar Cebollero Rivas,* Javier Hueto Pérez de Heredia

Servicio de Neumología, Complejo Hospitalario de Navarra, Pamplona, Spain

* Corresponding author.
E-mail address: pilar473@me.com (P.C. Rivas).

Contributions of the High Resolution Computed Tomography in the Early Detection of Silicosis☆

Aportaciones de la tomografía axial computarizada de alta resolución en la detección precoz de silicosis

To the Editor,

We are grateful for the opportunity to respond to the comments of Martínez González et al.[1] regarding our earlier communication[2] on the detection and description of a cluster of silicosis cases among young quartz agglomerate workers in Chiclana de la Frontera (Cádiz).[3] We will try to address the main points raised, despite the limitations imposed by some imprecise statements, which we, for our part, may have misinterpreted. We are concerned that our findings – and the conclusions drawn from them – have been described as mere opinions. The authors, by using only the International Classification of Radiographs in Pneumoconiosis of the International Labor Organization to argue against the validity of our results, appear to overlook the fact that the diagnosis were based primarily on the anatomical pathology results of four lung biopsies obtained by video-assisted thoracoscopy. When confirmation of a cluster of silicosis cases was received from the pathology department, high-resolution computed tomography (HRCT) was used to confirm the diagnosis in patients who were already symptomatic, nine of whom showed no changes on standard chest X-ray (CXR). Eight of these patients have currently been diagnosed with silicosis, including two who have developed complicated chronic silicosis.

In our procedures for screening and monitoring exposed workers, we do not underestimate the historically proven value of CXR. Nevertheless, after the appearance of several very severe cases, one terminating in death and another two waitlisted for lung transplantation, and in the context of the cluster described, HRCT, an accessible test with a very high positive predictive value, was used to improve the quality of the diagnosis. In an original article,[3] we raise the issue of difficulty in interpreting CXR, which were initially judged normal in some patients. Other authors have mentioned limitations such as wide inter-evaluator variability and underdetection in the diagnosis of silicosis.[4] In contrast, HRCT provides more information than CXR, particularly in the early stages of the disease,[5] as we were able to confirm in our series. HRCT is more sensitive and specific in the diagnosis of silicosis, revealing early subpleural rounded opacities in the lower lobes or mediastinal lymph nodes that could not be visualized on CXR.[6] The advantages of HRCT are substantial, since if silicosis is detected early in an exposed worker, quicker action can be taken to adapt the subject's employment and to reduce the chances of disease progression.

Thus, it seems unreasonable to dismiss as alarmist the publication of this series of cases associated with preventable exposure and

☆ Please cite this article as: Pérez-Alonso A, Córdoba-Doña JA, García-Vadillo C. Aportaciones de la tomografía axial computarizada de alta resolución en la detección precoz de silicosis. Arch Bronconeumol. 2015;51:528–529.