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.

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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

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serious consequences for public health, simply because they do not follow a standard diagnostic protocol. Indeed, standard diagnostic procedures were not ignored, they were only improved under the specific conditions of our clinical investigation. We are convinced that our study, and both the reflections that arose *a posteriori* and the general hypotheses generated from our initial findings are ethically correct, do not involve any conflict of interest, and respond to society's expectations of scientists. In this respect, one of the aims of the article was to combine our efforts with those of other clinicians and researchers interested in broadening our understanding of both the disease and the multiple interventions needed to reduce the impact of this form of silicosis in synthetic stone workers,[7] some of which have already been put into practice. We hope that these additional clarifications will be useful for advancing on both fronts.

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Bloody Expectoration as First Manifestation of Bilateral Kidney Cancer☆

Expectoración hemoptoica como primera manifestación de un cáncer renal bilateral

To the Editor,

Endobronchial metastasis (EBM) is rare and has been associated with breast, colon, kidney and pancreatic cancers. It can be asymptomatic or manifest as cough, hemoptysis or dyspnea, and is generally diagnosed during the course of the initial disease. We report the case of a patient with 3 bilateral renal tumors that first manifested as bloody expectoration.

A 76-year-old man with no toxic habits, coal-miner. Clinical history included left pleuritis as a young man, arterial hypertension, and diabetes. No significant family history was reported. He was referred to the respiratory medicine department due to 4–5 daily episodes of expectoration of red blood for some days, after cough. The patient was negative for fever, chest pain, dyspnea, extrathoracic symptoms, loss of weight and hematuria. Physical examination: good general condition, with mildly reduced breath sounds in the left hemithorax, no lymphadenopathies or masses. Clinical laboratory test results showed glucose 125 mg/dl and microhematuria. Lung function values were normal. Chest X-ray revealed aortic atheromatosis and left calcified pachypleuritis. Thoracoabdominal computed tomography (CT) revealed an intraluminal nodular lesion measuring 7 mm at the entrance of the right main bronchus (RMB), an expansive heterogeneous lesion of 6.6 cm in the upper pole of the right kidney, and another measuring 3.7 cm in the lower pole. Another lesion (2.6 cm) was observed in the upper pole of the left kidney. Fiberoptic bronchoscopy showed 2 vascularized polypoid lesions, one in the anterior aspect of the RMB (Fig. 1) and the other at the entrance of the right lower lobar bronchus. Biopsy results reported metastasis from clear cell carcinoma. Urine cytology testing was negative for malignancy. In view of the extension of the disease, no diagnostic procedures of the renal masses were initiated, and the patient was referred to the oncology department for treatment.

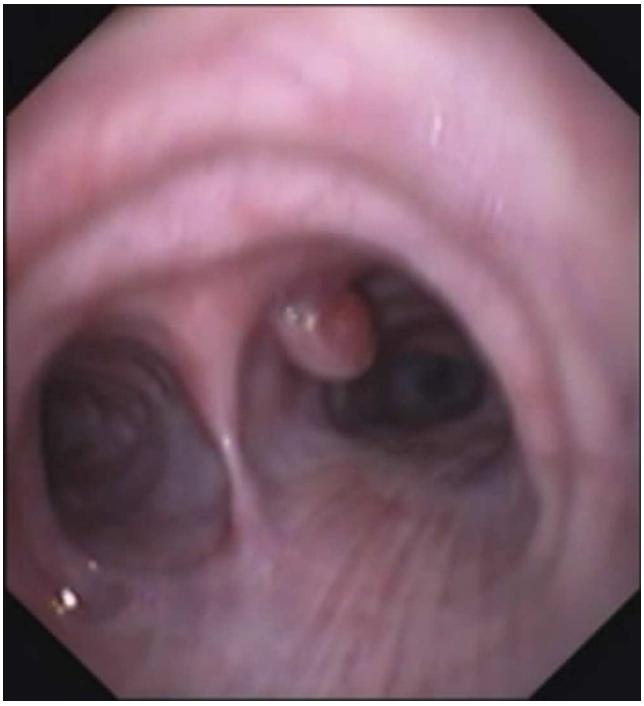

Fig. 1. Fiberoptic bronchoscopy, showing the lesion in the right main bronchus.

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