

Bronchial artery embolisation in the management of chronic recurrent haemoptysis

To the Editor—I read with interest the article on bronchial artery embolisation (BAE) written by Lee et al.¹ However, I have reservation on the conclusion drawn by the authors and stated in the title of the paper. The following are my comments and queries:

1. The clinical indication of BAE in acute major haemoptysis has been well accepted as it might be life-threatening if not promptly controlled. However, the usefulness of BAE in chronic recurrent haemoptysis (defined by the authors as having two episodes within 6 months) is questionable. If the authors wanted to assess the safety and effectiveness of this approach, it would appear more logical to compare outcomes in similar patients managed using conservative medical treatment.
2. If the investigators wished to compare the impact of BAE in acute major haemoptysis and in chronic recurrent haemoptysis, they should have tabulated patient demographics, associated clinical data, and outcomes in the two groups.
3. How could the investigators assess immediate

control of haemoptysis in the chronic recurrent haemoptysis group, when BAE was performed as an elective procedure after the symptom had ceased?

4. In this study, chronic recurrent haemoptysis was defined as 'two episodes within 6 months' and not requiring any other 'emergency visit,' whereas 'recurrence' of haemoptysis was defined as haemoptysis 'severe enough to warrant unanticipated medical attendance'. Could the authors explain why there was such a discrepancy in these definitions?

Based on the data presented, the title of the paper 'Bronchial artery embolisation can be equally safe and effective in the management of chronic recurrent haemoptysis' might be a bit misleading.

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Reference

1. Lee S, Chan JW, Chan SC, et al. Bronchial artery embolisation can be equally safe and effective in the management of chronic recurrent haemoptysis. *Hong Kong Med J* 2008;14:14-20.

Authors' reply

To the Editor—We thank Dr Wong for his interest in our paper. In our paper, the term "chronic recurrent haemoptysis" referred to patients who suffered from frequent episodes of disturbing and debilitating haemoptysis, which was not massive and not life-threatening. On the other hand, "recurrence" referred to the situation in which the haemoptysis leads to earlier or immediate clinical consultation. To date, there is no universally accepted consensus regarding these definitions, which vary and were made arbitrarily in the few papers on this topic. We agree that a more congruent definition would be more appropriate, especially in future studies on this topic.

Means of control for non-acute haemoptysis are very limited, especially for those who are not surgical candidates. Bronchial artery embolisation (BAE) may provide a useful alternative to this group of patients. However, few studies have been performed in this

area. Despite its retrospective nature, our result showed that BAE was safe and its efficacy, in terms of recurrence rate, was similar to that achieved with acute haemoptysis. We hope our paper can heighten the interest and lead to more studies in this area. We totally agree that a well-controlled, prospective study would yield more information on the use of BAE in the management of non-acute haemoptysis.

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