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Letters to the Editor

The New A/H1N1 Influenza: a Pandemic With a Great Many Protagonists

La nueva gripe A/H1N1: una pandemia con un sinfín de protagonistas

To the Editor:

We have read with great attention the editorial by Pérez-Padilla and Torre-Bouscoulet, recently published in *Bronconeumología*. Although we understand that your magazine specialises in respiratory illnesses, and taking into account that the article in question provides an excellent description of the measures implemented in Mexico City during the first weeks of the pandemic, we could not help but notice that the authors emphasise, in our opinion excessively, the central role of pulmonologists in the control and treatment of said pandemic. We sincerely believe that these situations often arise through an understandable desire to obtain prestige. Along these lines, recently a group of authors, also Mexican, highlighted the role of emergency services in Mexico City in the first days after the breakout took place.² It is unquestionable that influenza has always proven a great challenge to medicine³ and, therefore, pulmonologists as well as emergency doctors, infectious disease specialists, epidemiologists, microbiologists, internists, intensive doctors, and general practitioners, to mention only some of the specialists involved in treating these patients, are going to have a great deal to say and do in the upcoming months.^{4,5} Multidisciplinary work is the base of modern medicine, and all who participate in patient care should be duly recognised. This is the only way possible to make advancements, not only in medical care, but also in research of the

processes and illnesses that the medical profession faces on a daily basis. An example of this cooperation is evident in case descriptions of the first A/H1N1 influenza cases treated in Spain, the publication of which was made possible by contributions from various medical specialties.⁶ If the worst case scenario occurs, even if only in terms of an increase in medical care demand in the next winter immunization programme, there will be work and prestige for all.

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Effectiveness of Bosentan in the Management of Latin American Patients Diagnosed With Pulmonary Arterial Hypertension

Efectividad del bosentan en el manejo de pacientes latinoamericanos con diagnóstico de hipertensión arterial pulmonar

To the Editor:

Pulmonary arterial hypertension (PAH) is a severe disease with several etiologies and common pathophysiological mechanisms.¹ Various pharmacologic options have been proposed, although they have considerable disadvantages.² Bosentan, an endothelin-1 receptor antagonist, has shown functional improvement in patients diagnosed with PAH, although its effect on hemodynamic parameters is more discreet.³

We report on a series of 6 Latin American females diagnosed with severe PAH treated with bosentan and followed for up to 16 months (mean, 10.8 months). At 12 weeks, a considerable improvement was observed in the 6-minute walk test result (321.25 m [baseline] vs 428.25 m), and this trend was maintained over time (490 m at 7 months). A significantly decreased functional class (modified New York Heart Association) was observed at 3 and 7 months (classes II and III, respectively, vs class IV [baseline]). No patients were admitted due to right heart failure or syncope, and no patients died during follow-up or experienced increased transaminase levels (Table). Neither tricuspid insufficiency nor systolic pulmonary pressure measured by echocardiography changed remarkably.

To our knowledge, this case report is the first published experience with Latin American patients. The improved functional parameters and the modest change in hemodynamic data are similar to previously published findings in other populations.⁴

Table
Change in Functional Parameters Between Starting Treatment With Bosentan and Follow-up

		Mean	SD	P
6-MWT	Baseline	334.2	71.6	.014
	Follow-up	467.0	34.0	
NYHA	Baseline	3.8	0.4	.013
	Follow-up	2.7	0.5	
SPP measured by echocardiography	Baseline	97.3	35.7	.234
	Follow-up	110.5	33.8	

Abbreviations: NYHA, New York Heart Association; SPP, systolic pulmonary pressure; 6-MWT, 6-minute walk test.

The prognosis of PAH has altered since the advent of the prostanoids. These drugs induced a rapid improvement in hemodynamic parameters and exercise capacity, and increased survival. However, their short half-life and mode of administration (epoprostenol, intravenous; iloprost, inhaled; treprostinil, subcutaneous) significantly limit their use. Shortly afterwards, beraprost, an orally active prostanoid, proved beneficial, but its effects were not maintained over time.

Studies with sildenafil provided similar results to those of prostacyclin derivatives. Recent publications report improved functional class, response to effort, and a tendency toward decreasing systolic pulmonary pressure. These findings are associated with those reported for endothelin-1 receptor antagonists.⁵

Platelet-derived growth factor acts as a potent mitogen and chemoattractant in vitro, and it intervenes in the distal extension of the pulmonary vascular smooth muscle cells into small nonmuscular arterioles. Hence current research into imatinib, a platelet-derived growth factor antagonist, for use in this condition. García et al⁶ present 4 cases of patients with severe PAH (functional class IV) whose treatment with prostanoids, sildenafil, or bosentan was combined with imatinib. All the patients in this small series died after starting the drug, although their disease was advanced and their prognosis was very poor.

Based on results published to date on treatment of PAH, bosentan continues to be a valid option. Therefore, we feel that it is important

to provide information on cases of patients from other population groups who have been treated with this drug.

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A United Airway: Bronchiectasis Is Also Associated With Chronic Rhinosinusitis and Nasal Polyps

Una vía respiratoria unificada: las bronquiectasias también se asocian a rinosinusitis crónica y pólipos nasales

To the Editor:

In November 2008, *Archivos de Bronconeumología* published the guidelines of the Spanish Society of Pulmonology and Thoracic Surgery (SEPAR) on the diagnosis and treatment of bronchiectasis.¹ Although the document is extremely important for the diagnosis and treatment of bronchiectasis, it makes no mention whatsoever of the impact of this disease on the upper airway in the form of chronic rhinosinusitis with or without nasal polyps, a fact which was pointed out in a review article published in this journal in 2006.²

The concept of a *united airway* has been demonstrated through epidemiologic, pathophysiologic, diagnostic, and therapeutic associations between bronchopulmonary and sinonasal disease. Reported associations include asthma with allergic rhinitis,³ asthma with nasal polyposis,⁴ and nonallergic asthma and chronic obstructive pulmonary disease (COPD) with chronic rhinosinusitis.⁵ Several

years ago, prompted by our clinical experience, the otorhinolaryngology and pulmonology departments at Hospital Clínic de Barcelona, Spain started to investigate the association between sinonasal disease and bronchiectasis.

Our research has resulted in the publication of 2 articles^{6,7} (with a third in press) on the association between bronchiectasis and chronic rhinosinusitis with or without nasal polyposis. Interestingly, 1 of the studies found that 3 out of every 4 patients with bronchiectasis (77%) met clinical and radiologic criteria for chronic rhinosinusitis while 1 out of 4 (25%) had visible nasal polyps on nasal endoscopy.⁷ These results support the concept of a united airway and indicate that there could be a yet unknown process in postinfective bronchiectasis that may affect the entire airway. Furthermore, patients with bronchiectasis and chronic rhinosinusitis have a poorer quality of life, measured by both generic and specific questionnaires, than those with bronchiectasis but without chronic sinonasal disease.⁶

From these results we can conclude that all patients with bronchiectasis should be clinically assessed by nasal endoscopy and/or sinus computed tomography for the purpose of confirming a possible diagnosis of chronic rhinosinusitis with or without nasal polyps. Consequently, all patients with bronchiectasis, or indeed with asthma and COPD, should undergo an ear, nose, and throat