Correspondence

Chronic obstructive pulmonary disease in rheumatoid arthritis

Sir,
We read with interest the study by Shen et al. in which rheumatoid arthritis (RA) was found to be an independent risk factor for the development of chronic obstructive pulmonary disease (COPD). The authors have taken the combined effects of smoking and RA on the incidence of COPD. It would have been useful if authors had done a sub-group analysis of COPD incidence between smokers and smokers in both RA and control group. Also, treatment of RA, in the form of corticosteroids and disease modifying agents, might have affected the initiation and progression of COPD in RA group. Lastly, respiratory failure is one of the leading causes of death in RA patients. Hence, evaluation of response to COPD treatment and the overall patient prognosis in both the groups would might have added useful interpretations to the study.

The finding of increased COPD incidence in RA opens new insight into the complex pathogenesis of COPD. Further studies are required to unfold the pathogenic basis as well as the prognostic implications of their association.

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doi:10.1093/qjmed/hcu178
Advance Access Publication 30 August 2014

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Reply: chronic obstructive pulmonary disease in rheumatoid arthritis

Sir,
We are grateful to Dr Aggarwal for his interest in our article. In this study, we considered the combined effects of rheumatoid arthritis (RA) and smoking lead to increase the incidence of chronic obstructive pulmonary disease (COPD). Although the smoking rate was estimated to be only ~4% among Taiwanese females, they represent almost 80% of the case group. We have listed this point in the study limitation. We totally agree that a future study with four subgroups (RA smokers, RA non-smokers, non-RA smokers, non-RA non-smokers) will be ideal.

Although respiratory failure is one of the causes of death in RA patients on autopsy, we would not consider it for the clinical evaluation of prognosis. On clinical performance, respiratory failure can be acute, chronic and even both. In addition, respiratory failure is a syndrome with several kinds of mechanism such as low fraction of inspired oxygen (FiO2), hypoventilation, ventilation/perfusion ratio (V/Q) mismatch, shunt, and diffusion impairment. Respiratory failure is not affected only by COPD or RA. Another concern is that respiratory failure may be an inaccurate and inadequate diagnosis on death certificates. Hence, instead evaluating respiratory failure, we suggest evaluating the incidence of pneumonia or COPD acute exacerbation for evaluating prognosis.

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