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Use of Bronchoscopy for the Diagnosis of Abnormalities in Upper Thorax

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Commentary

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DESCRITPION

Bronchoscopy is the procedure used most commonly to diagnose lung cancer. Approximately, 1,70,000 new cases of lung cancer occur annually. Lung cancer may present as an endobronchial lesion, as a peripheral lesion or as a hilary mass. Bronchooscopy is useful in establishing the diagnosis in each of these instances. The flexible bronchoscope is invaluable in examining the central airways to localize and diagnose endobronchial lesions. The appearance of an endobronchial tumour varies from an exophytic mass to subtle submucosal abnormalities. The diagnostic yield varies with the size and location of the tumour. Bronchial washings, bronchial brushings and EBB have been employed in various combinations to establish a diagnosis of malignant disease. If an endobronchial lesion is visible, bronchoscopy with bronchial brushing and EBB will be diagnostic in more than 90% of cases. With endobronchially visible lesions 3-5 biopsies are usually sufficient.

The diagnostic yield is increased when bronchial brushing is combined with biopsy. It is controversial as to whether the addition of bronchial washing to bronchial biopsy and bronchial brushing increases the yield with endobronchially visible lesions. The value of TBNA in conjunction with bronchial washings, bronchial brushings and EBB in the diagnosis of endobronchial disease. They found that the addition of TBNA to routine bronchoscopic sampling increased the diagnosis of endobronchial disease. TBNA is also useful in the diagnosis of submucosal tumours that may present as erythema, loss of bronchial markings, or a thickening of the mucosa. TBNA may also be useful in tumours that extrinsically compress the bronchial lumen.

Some lung carcinomas are located in the parenchyma of the lung and are not visible endoscopically. The diagnostic approach to these lesions involves the use of each of the sampling methods available to the bronchoscopist; bronchial washing, bronchial brushing, transbronchial biopsy, TBNA and BAL. The diagnostic sensitivity for these masses and nodules ranges from 37% to 80%. Use of multiple sampling methods increases the diagnostic yield for these lesions. Multiple factors influence the broad range in the results of these studies, including the size and distance from the hilum, sampling methods and means used to localize the lesion. For example some studies evaluated the value of BAL in patients with suspected peripheral lung carcinoma without the use of fluoroscopic guidance. They found a 50% yield in the diagnosis of lung cancer in these patients using BAL, TBNA has also been used successfully to increase the diagnostic yield in these peripheral sessions. As with TBB the successful retrieval of diagnostic material using TBNA depends on the size of the mass. The yield for lesions 2 cm size is approximately 33% and 76% respectively. Location of the lesion in the upper or lower lobes does not seen to influence the diagnostic yield, but the use of fluoroscopy or other imaging modalities is necessary when attempts are made to biopsy to these lesions. In an effort to diagnose lesions 2 cm in diameter used an ultrathin bronchoscope with virtual bronchoscopy to localize these lesions. In their study the average size of the lesions was 1.32 cm lesions. In the remainder six lesions had insufficient samples and three were not accessible. Thus the use of an ultrathin bronchoscope with virtual bronchoscopy navigation was useful in the diagnosis of small peripheral lesions.