Letters to Editor

Clinicopathological profile and course of malignant pleural effusion in a tertiary care teaching hospital in western Uttar Pradesh with special reference to lung cancer

Sir,

We would like to thank Sharma et al.\(^{[1]}\) for acknowledging our work\(^{[5]}\) and raising a few important points about malignant pleural effusion and female genital tract cancer.

Female genital cancers were not discussed in detail in our study as that was not the primary aim. Our study was conducted in a resource-limited manner regarding the cost and availability of tests. We cannot but agree with the authors that immunohistochemical and molecular markers must be used to diagnose cancers of unknown primary and pass on the benefit of targeted treatment.

Our study had 30 cases involving the female genital system, of which 28 were ovarian cancers and one each cervical and endometrial cancer. Patients of malignant pleural effusion with ovarian cancer have intermediate prognosis, better than lung cancer but worse than breast cancer.\(^{[3]}\) In our study, too, only 10 out of 135 (7.4%) patients of lung cancer survived for 6 months, while 4 out of 30 (13.3%) ovarian cancer patients and 8 out of 36 (22.2%) breast cancer patients were alive after 6 months follow-up.

In another study\(^{[4]}\) by us titled “Malignant pleural effusion in carcinoma ovary: Experience of a tertiary care teaching hospital in northern India,” published in *Indian Journal of Basic and Applied Medical Research*, we found cancer antigen 125 (CA-125) to be a highly sensitive marker, which fell significantly to a low level with treatment and rose again on recurrence (5745.59 IU/L vs 778.50 IU/L vs 4785.85 IU/L).

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**REFERENCES**

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Sir,

I went through the article entitled “A comparative study of itraconazole in various dose schedules in the treatment of pulmonary aspergilloma in treated patients of pulmonary tuberculosis” published in “Lung India” (2015; 32:342-6) with interest.

The authors deserve appreciation for their effort. However, I have a concern regarding this study. The authors state that the study patients randomly received itraconazole either in a fixed dose schedule of 200 mg (group I) 200 mg twice daily (group II) or a variable dose schedule (group III) for 12 months. The authors further state that 60 patients were enrolled, 20 in each group, and that there were no intergroup differences with regard to age, sex, body weight, smoking status, alcohol intake, symptoms, potassium hydroxide (KOH) mount, fungal culture, pattern of radiological lesions, or antiaspergillus antibodies (anti-Asp-Ab) titers.

The authors have actually conducted a clinical trial and not a randomized trial. Conducting a randomized trial in a clinical setting is difficult. Furthermore, there is practical difficulty in conducting randomization on a sample size such as the one used by the authors. Small study samples limit the use of randomization. Randomization in its simplest form is like the tossing of a coin; therefore, the chance of being equally distributed in two groups in a small sample is rare. Now, imagine tossing a coin 60 times. How much probability is there for heads or tails? In the rarest of situations, it will be 30:30. As is apparent, the authors have chosen a deterministic pattern for choosing study participants, which is nonrandom. This pattern is further highlighted in the statement of the authors. The authors state that there are no intergroup differences in the three groups chosen for the purpose of this study. By all probabilities, this is impossible in a random selection of study participants.

To make the point clearer, there are two processes involved in randomizing patients to different interventions. The first is choosing a randomization procedure to generate an unpredictable sequence of allocations. This may be a simple random assignment of patients to any of the groups at equal probabilities; it may be “restricted,” or may be “adaptive.” A second and more practical issue is allocation concealment, which refers to the stringent precautions taken to ensure that the group assignment of patients is not revealed prior to definitively allocating them to their respective groups. Both of these procedures are effective in generating patient distribution capable of yielding unbiased results.

The authors seem to have chosen nonrandom “systematic” methods of group assignment such as alternating subjects between one group and the other. “Limitless contamination possibilities” and can cause a breach of allocation concealment.

REFERENCES
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