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Health-related Quality of Life

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nations for each of the SLE criteria we mentioned above. However, as a group, these criteria overwhelmingly support the diagnosis of SLE.²

Dr. Marvisi suggested the interstitial lung inflammation might be due to idiopathic pulmonary fibrosis (IPF) and/or hepatitis C-associated essential MC. The finding of capillaritis on our patient's transbronchial biopsy did not support IPF. Dr. Marvisi himself has kindly provided the reference refuting the association between hepatitis C and IPF.⁸ Although cryoglobulinemia may be present in patients with either hepatitis C or SLE,^{6,9} it would not have altered the diagnosis in our patient. We found one case report of *lymphocytic* pulmonary vasculitis associated with hepatitis C, cryoglobulinemia, and glomerulonephritis.¹⁰ Our patient did not have lymphocytic vasculitis. In an extensive review of the histopathology of pulmonary capillaritis, Green et al reported that pulmonary capillaritis has not been described in essential MC.⁴

Although hypoxemia may be associated with cirrhosis, our patient's hypoxemia and diffusion abnormality significantly improved with the administration of corticosteroids. Lupus pneumonitis often remains a diagnosis of exclusion, and as such, other explanations should always be considered.

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strated that there was a subgroup of patients (group 2) who had poorer HRQL and did not benefit from the rehabilitation program.

Much of the discussion focuses on explaining the reasons for the differences in HRQL between the groups. The authors say that group 2 likely "...faced far more serious physical and psychological barriers." The impact of more physical constraints is unlikely given the exclusion of patients with severe disability and the equivalent baseline pulmonary function tests. However, we suspect that psychological barriers may be responsible for some of their findings.

We feel that the authors have met some common pitfalls in their study of quality of life (QOL). Although the authors tapped into the patients HRQL, they failed to make a complete assessment of QOL by neglecting the overall QOL and the patients' subjective assessment of QOL. Such measures are useful at tapping into aspects of a patient's life which may affect outcome, but which are not directly related to the person's physical or health-related QOL.² For example, a person may have acceptable pulmonary function measures and acceptable HRQL scores, but still report a very poor overall QOL if they have other problems in their life (eg, emotional problems). Linear measures of overall QOL, and obtaining subjective input on their QOL would offer insight into these areas.

The authors recommend that patients like those in group 2 be identified and be offered less intensive aftercare. One could argue that patients in group 2 had similar overall QOL to group 1, but this was simply not detected because of the use of only a measure of HRQL. Their recommendation could result in denying eligible candidates opportunities at gaining benefits from rehabilitation.

Ketelaars et al¹ add to the literature on the benefits of pulmonary rehabilitation on QOL in COPD. Their study would have added further, and would have left the authors with fewer speculations regarding their results, if they had broadened their definition of QOL and allowed for the patients' subjective input. In limiting one's definition and assessment of QOL to only *health-related* QOL, one often misses tapping into what one is truly measuring.

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To the Editor:

We have read the letter from Limbos and Joyce commenting on our article published in *CHEST* in August 1997.¹

We believe that the comments made by the authors of this letter are not valid. HRQL as measured by the St. George's Respiratory Questionnaire (SGRQ) has three components: symptoms, activities, and impact on daily life. The "symptoms" component contains items related to the level of symptomatol-

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What is Being Measured?

To the Editor:

Ketelaars and colleagues (August 1997)¹ recently found that health-related quality of life (HRQL) improved in patients with COPD following a rehabilitation program. They then demon-

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