To the Editor:

We thank Lamb and colleagues1 for their recent article in CHEST (January 2010) addressing the need to standardize the training of interventional pulmonologists. We also appreciate the corresponding editorial by Ost et al2 that provided additional points of discussion. We agree that setting up strict criteria regarding the volume of procedures required may significantly limit the availability of these techniques to our patients. Many formally trained interventional pulmonologists have not met all the suggested standards, and current interventional pulmonary programs may close if unable to meet strict volume requirements. Additionally, we put forth that some procedures considered to be “interventional” perhaps should be part of the training of every general pulmonologist. For instance, in our fellowship program, we strive to train all our fellows to use endobronchial ultrasoundography and to perform balloon bronchoplasty. We believe that learning curves are highly individualized and, hence, that the final decision to certify an individual to perform a procedure should be left to the program director and not be limited to procedure volumes.

We believe that certain interventions can be performed by pulmonologists who may be qualified to perform a particular procedure but not the whole scope of all available interventions. However, we also maintain that when dealing with more complicated patient airways, care should occur within a center capable of performing all foreseeable interventions.

We agree that short, 1- or 2-day interventional pulmonary courses should not be considered sufficient for training. Nevertheless, such courses that also are aimed at the general pulmonologist have become common and often include hands-on practice sessions. We need to make sure that we are not sending a contradictory message. We see their value as a way to disseminate the understanding of the available therapies and to improve patient access and referral. Such courses also serve to update the practicing interventional pulmonologist. With regard to the general practicing pulmonologist, these courses should perhaps emphasize training to deal with airway emergencies, such as the removal of foreign bodies.

Clearly, there is no consensus on the need to have strict interventional pulmonary fellowship programs. Regardless, as a profession, we must strive to provide our patients with the best possible care. Further, we must all remain aware of our limitations and refer our patients to where they can be treated with the best and safest approach. We welcome and commend our colleagues for bringing up these interesting issues.

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REFERENCES

Response

To the Editor:

We thank Drs Rubio and Boyd for their excellent points regarding our article.1 Their main concerns boil down to access to training and the final arbiter of training, both of which affect the availability of procedures we can offer our patients. The goal, however, of providing quality procedures by well-trained operators should not be compromised.

We do not propose to limit availability. Individuals well trained by experienced practitioners should be able to offer any specific procedure. We agree that training in isolated procedures such as endobronchial ultrasound may be incorporated into existing fellowship programs. The goal of our article, however, was to provide a framework for a larger spectrum of procedures, support training in the field of interventional pulmonology, and define the didactic and procedural training required for a dedicated interventional pulmonologist.

We agree with Drs Rubio and Boyd that weekend courses offer familiarity, not definitive training. These courses provide the practicing pulmonologist with an understanding of options and limitations. For some, they provide the motivation to seek further training. For those in fellowship, individual procedures may be mastered, but this highly depends on the offerings and expertise within each fellowship program. Patsis et al3 made the sobering point that our basic programs often do not provide sufficient training in many basic, let alone advanced, procedures.

Take, for example, the history of transbronchial needle aspiration. In itself, it was a pivotal procedure used in the diagnosis and staging of thoracic malignancies. Introduced in the 1970s as a