Single Bronchoscope Combined Endoscopic-Endobronchial Ultrasound-Guided Fine-Needle Aspiration for Tuberculous Mediastinal Nodes

To the Editor:

We fully support the use of a single linear endobronchial ultrasound (EBUS) bronchoscope for both endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) and endoscopic ultrasound-guided fine-needle aspiration (EUS-FNA) of mediastinal lymph nodes, as reported in the recent CHEST article by Herth et al. Having initially established and reported our own results with EBUS-TBNA for both malignant and benign disease, we have more recently moved to performing EUS-FNA and EBUS-TBNA with a single linear EBUS bronchoscope for benign and malignant nodes. We would like to add the particular utility of EUS-FNA in nonmalignant disease as well as the more common utility in malignant disease. In our first five combined EBUS-TBNA/EUS-FNA procedures via a single EBUS bronchoscope, three patients with suspected TB (enlarged subcarinal and hilar nodes but no parenchymal lung disease) had TB diagnosed (caseous granulomatous histologic results with positive TB culture) from the EUS-FNA only (with only one positive histologic examination and culture from EBUS-TBNA, and all negative on BAL). In addition, the antibiotic sensitivities from mediastinal lymph node culture are helpful to ongoing management of the TB. The remaining two cases were for suspected malignancy, metastatic renal cell carcinoma and non-small cell lung cancer, which were confirmed at EBUS-TBNA and EUS-FNA of subcarinal nodes.

We have also found EUS-FNA more tolerable to some patients than EBUS-TBNA, particularly those with pronounced cough despite adequate conscious sedation and those with poor lung function and significant comorbid lung disease. This can be particularly helpful if Station 7 is a target or there is a paraesophageal lymph node. Obviously, the cost savings of another EUS scope are also welcome in resource-rationed health-care systems. In summary, combined EUS-FNA/EBUS-TBNA is likely to become more commonplace for all the above reasons but should not be overlooked in the diagnosis of benign disease accessible by this technique.

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Increased Mortality in Patients Without Ventilator-Associated Pneumonia

To the Editor:

In regard to the recently published article in CHEST by Afessa et al (May 2010), the association between silver-coated tracheal tubes and reduced mortality in patients who developed ventilator-associated pneumonia (VAP) was interesting. However, more intriguing and much more concerning was the observation that silver-coated tubes were associated with increased mortality in patients without VAP. This is particularly relevant given that in most institutions, the number of patients who do not develop VAP vastly outnumber those who do, implying that silver-coated tubes may result in an overall excess in deaths. This concern is borne out in the original North American Silver-Coated Endotracheal Tube (NASCENT) trial, in which mortality was higher in the group randomized to receive silver-coated endotracheal tubes (30.9% vs 27.3%, P = .08). Although this difference did not reach statistical significance, the strong trend raises significant concerns about the safety and overall benefits of the silver-coated endotracheal tube. Extrapolating the mortality figures published by Afessa et al to Harborview Medical Center in Seattle, Washington, it is estimated that routine use of the silver-coated endotracheal tube in our institution would result in an excess of 54 deaths per year. It would be helpful if the authors could comment on this concern and on the potential mechanism for increased mortality related to the silver-coated endotracheal tube.

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References


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