EDITORIALS

Publication Cures for Which There is No Disease

A recent news release stated, "Almost one-third of the papers presented at meetings never see journal publication. As a result, much valuable information has, in the past, been lost." There is a pejorative ring to this declaration and an implied evangelical exhortation to the international medical community to correct a grave lack of communication. "Corrective measures" have been proposed, and it will come as no surprise to the clinician and investigator that these solutions have included the publication of yet another medical journal! Frantic efforts to publish all papers presented at medical meetings offer a solution for which there is no problem.

Let us consider first the accusation that international medical congresses offer critical information which should be transmitted to those who did not attend. As presently constituted, international conventions are structured in response to complex motivations. One impetus for these congresses is the desire to provide an opportunity for scientists from many countries to engage in informal dialogue. This is not an unworthy goal, for it has been repeatedly shown that medical communications can remain open when many other avenues of communication have been destroyed. It is not a small achievement to enhance discussion among physicians from widely diverse socio-economic and political environments.

Selection of papers is not invariably based on criteria constituting a single standard of excellence. Frequently, planning committees must consider an overriding responsibility to provide adequate geographic representation. Thus, an uneven caliber of scientific reports does not imply that the planning was inept or mischievous. However, regardless of the stature of the formal presentations, these conventions offer speakers and student registrants the opportunity to participate in instructive discussions during the face-to-face encounters that so naturally occur at lunch or at evening social activities.

Is it heresy to insist that many of the most successful efforts at "medical diplomacy" and informal scientific interchange serve a vital function even if published proceedings never appear? Indeed, it is a profound disservice to both author and reader to publish that which is best transmitted by verbal communication. There are, of course, many symposia and congresses in highly specialized fields which have a major priority of eventual publication of the program. The scientific caliber of these reports is often uniform and lends itself to distribution via titles, abstracts or full papers. However, the customary format for the less specialized conventions is not of this nature; the latter possibly account for the majority of the many thousands of papers presented each year at international meetings. The contention that only by publication of proceedings can we save invaluable convention papers from obscurity is an unfounded fear. Every speaker should know that an excellent paper presented at any type of convention will receive the respectful attention of medical editors. There are an adequate number of superior medical journals to provide for publication of the significantly original investigative report. In addition, many editorial boards are eager for authoritative reviews which provide clinical guidance for the practitioner.

The value of convention papers is directly proportional to the scientific skills and responsibility of the scientific program committees. Even in the most optimal of circumstances, however, it is difficult to evaluate the true status of research from the brief abstracts which serve as the basis for acceptance of convention papers. Review of complete manuscripts by editorial boards provides the best and ultimate judgment of the merits of an investigation. Wholesale citation of titles listed only because the speaker once stood at a podium can only impose an insufferable burden upon those who become entrapped in fruitless quests for reports which may contain little of substantive value.

Much of what has been noted in this analysis of international meetings also applies to state, regional and national meetings within the United States. Particularly harmful is the current competitive drive to produce books, manuals and proceedings based upon postgraduate courses.

These criticisms are not intended to convey a complacent view that all is well in biomedical
To Needle, Brush, Cut or Watch?

The pulmonary nodule does indeed remain a diagnostic dilemma. Until the mid 1960’s, most of the limited diagnostic procedures for pulmonary nodules had such a low specific diagnostic yield that the clinician had essentially two choices: 1) to recommend diagnostic thoracotomy, or 2) to observe, usually with repeated x-ray examinations. Proponents of each approach could accumulate or quote the series necessary to support their surgical or observation approach. Unfortunately for the individual patient, statistics offered little solace when the “wrong” approach was chosen.

In this issue of Chest, Zelch et al (see page 149) present their recent experience with percutaneous needle (noncutting) aspiration biopsy of solitary nodules. Their 93 percent accuracy in separating benign from malignant lesions is excellent, as is their 0 percent mortality with no “major” morbidity. Both figures assuredly reflect good technical skills and experience of the operator, as well as the talented support of the cytologist-pathologist. From their experience they feel that needle aspiration is quicker and “easier” on the patient than the bronchial brushing approach popularized by Fennessy. Both diagnostic approaches have very similar indications, limitations, complications and results and, therefore, the choice to needle or brush depends largely on the operator’s experience. Our experience at the University of Colorado Medical Center leads me to recommend brushing of the more central lesion and needle aspiration of the more peripheral lesion. The larger the lesion the more I favor needle aspiration, as the center of the lesion can be entered where the more diagnostic tumor cells or infectious organisms are present. The periphery of larger nodules tend to give misleading inflammatory necrotic cells in both cancer and granuloma.

The question that must be asked of all non-thoracotomy “procedurists” is what happened to their false negative (cancer cases thought to be benign) cases? Did a delay in making the right diagnosis allow a potential resectable curable cancer to progress to an incurable cancer? One can minimize this true disaster by considering all patients with nondiagnostic results (ie, no cancer, Tuberculosis, cysts, etc) as diagnostic thoracotomy candidates. If the patient is in the 40 to 60 year age range with a marked smoking history one usually recommends early thoracotomy for undiagnosed nodules; however, for a high surgical risk patient in his 70’s the best medical judgment (after considering one’s own false negative percentages vs the local mortality rate from a diagnostic thoracotomy) may still be a period of observation and/or repeating “safer” diagnostic procedure.

The new procedures, therefore, have eliminated the need of “diagnostic thoracotomy” in 50-75 percent of patients with pulmonary nodules; however, selection and experience are still needed for any individual case.

Thomas A. Neff, M.D.*
Denver

REFERENCES
1 Steele JD: The Solitary Pulmonary Nodule. Springfield, Ill., Charles C Thomas, 1964

Insertion Site for Heart Catheters

Heart catheterization, widely accepted and used for cardiac physiologic and anatomic assessment over the past three decades, is still being refined and evaluated in its practice and application. Historically, catheters were first introduced into the heart of man through arm veins and arteries. In most laboratories this is still the preferred route. However, a number of heart laboratories now utilize the femoral approach because of ease of catheter introduction and manipulation. Rao, (see page 239) presents data documenting the virtues of the femoral route for infant and child catheterization. Special emphasis is given to the fact that entrance to the left heart was gained in 64 percent of pediatric femoral vein catheterizations.

Among those dealing with congenital heart disease, it is well established that entry into the left