The ACCP Council on Critical Care

The Critical Care Council of the American College of Chest Physicians was formally established by the Board of Regents in October, 1982 at the XIV World Congress on Diseases of the Chest in Toronto, Canada. This clear-cut affirmation of the College's long-established role in enhancing the care of the critically ill was prompted by the increasing number of ACCP members who desire a focal point within the College to address the many developing issues related to critical care.

The ACCP, through its Council on Critical Care, will bring to bear the full spectrum of knowledge, skills, and experience incorporated in the many disciplines of its members—pulmonologists, thoracic surgeons, cardiologists, anesthesiologists, etc. Consistent with this diversity of competencies, we reaffirm that: 1) it is essential to incorporate the individual skills of the various traditional vertical disciplines of medicine to achieve excellence in the care of the critically ill; and 2) excellence in care may best be achieved by applying the most highly honed knowledge and skills of these vertical disciplines to those most in need of them—the critically ill.

Many of the disciplines within the ACCP focus on the quintessence of critical care—respiration in its totality. Respiration, in this truest and historic sense, incorporates: 1) the lung-gas exchange including ventilation (V); 2) the heart-oxygen (and CO2) transport including cardiac output (Q); and 3) cellular respiration epitomized as oxygen consumption (VO2).1 It is important to recognize that not all the disciplines of the College have this focus, eg, radiology, pathology, occupational medicine, etc (albeit they may make specific critical contributions) and that the disciplines of the College do not represent the universe that may be required for the care of some of the critically ill, eg, neurosurgery, orthopedics, urology, nephrology, hematology-oncology, etc. In addition, the disease process or circumstance of some patients may warrant special units: neurosurgery, burn, postanesthesia, recovery, dialysis, etc.

The multidisciplinary commitment of the College to fostering excellence in the care of the critically ill through continuing education ("the university without walls") and research has always been apparent in all its activities—Chest, the annual scientific assembly, postgraduate courses, Clinical Challenge, audiovisual materials, and monographs (Critical Care, in press). This emphasis on the multidisciplinary nature of the problems of critically ill patients has been clearly stated in the committee report, "Essentials of an Intensive Respiratory Care Unit" and related editorials in Chest in 1971.2,3 The committee recognized both acute and chronic respiratory failure due to non-respiratory, as well as respiratory etiologies. They recognized the need for competence in all aspects of respiration as just defined, the additional requirements (people) for treating renal failure, neurologic care, etc, the required administrative skills, and the necessary facilities. A perusal of the College's educational vehicles confirms the striking momentum in both quantity and quality of critical care contributions which antedate the committee report just cited. The Council on Critical Care is delighted to further this involvement by announcing a new section in Chest on Critical Care and its contributions to the 1983 annual scientific assembly. In addition, the Council will assume responsibility for initiating and coordinating with existing committees, sections, and forums, all the educational activities of the College related to critical care.

The Council on Critical Care will also actively: 1) serve as a monitor of government and other credentialing, planning, or regulatory bodies that may be involved in critical care; 2) provide information to such agencies that may assist them in decision-making, including the College's position when appropriate; 3) strive diligently to coordinate the activities of the College with other medical organizations with a common purpose; and 4) serve as a fact-finding body and sounding board for all critical care concerns of College members.

To this last end, we invite all members of the College who consider critical care to be an important component of their professional life to join the Council on Critical Care. The Council is an entirely new and unique component of the College which transcends, as does critical care, the sections and forums. It was specifically established to permit College members an additional focus in critical care without interfering with their traditional and continuing areas of interest as represented by the sections and forums. Thus, the Steering Committee of the Council on Critical Care
enthusiastically welcomes your membership. An invitation to each member has been mailed.

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Members of the Steering Committee: Roger C. Bone, Little Rock; James E. Dalen, Worcester, MA; Thomas B. Ferguson, St. Louis; Jerome H. Modell; Gainesville, FL; Alan L. Plummer, Atlanta; Sylvan Lee Weinberg, Dayton; Ex officio: W. Gerald Rainer, Denver, Alfred Soffer, Dale E. Braddy, Park Ridge, IL.

Interested ACCP Fellows may write the Sections and Forums Office, 911 Busse Highway, Park Ridge, Illinois, for information.

REFERENCES

1 Weg JC. The respiratory intensive care unit. In: NIH Consensus Development Conference on Critical Care medicine (program abstracts). Bethesda: March 7-9, 1983
4 Soffer A. The chest physician and intensive care (editorial). Chest 1971; 59:474-75
5 Petty TL. Respiratory care is mod! (editorial). Chest 1971; 59:475-76

Bronchoscopy for Endoscopically Visible Carcinoma of the Lung

The introduction of the flexible fiberoptic bronchoscope (FFB) has revolutionized the endoscopic examination of the tracheobronchial tree. The ease of introduction, its use and adaptability as an office procedure, and the greatly expanded indications for its use as a diagnostic and therapeutic tool has made the FFB an instrument used as frequently by pulmonologist as by thoracic surgeons.

The early diagnosis and treatment of many infiltrative diseases made possible by this technique has changed the concept and curability of many of these disease states. The volume of literature in this vein in recent years attests to the fact.

There is, however, the patient who presents with x-ray film findings of a mass lesion or hemoptysis where carcinoma heads the list of differential diagnosis. The pervading pessimism as to survival in such patients is all too common among physicians. The article by Shure and Astarita in this issue (see page 865) presents an erudite scientific project planned to prove that five biopsy specimens are enough to provide a diagnosis. This was written to dispute a previous article claiming that nine biopsies were needed in the case of an endobronchial tumor.

This editorial raises the question: Which specialist should most appropriately perform the diagnostic test in a given situation?

Delays in treatment have resulted from nondiagnostic endoscopies. When carcinoma is suspected, rapid determination of cell type and extent of disease is mandatory. For lung cancer, surgery is the only treatment modality with any long-term survival rate. Resected stage I nonsmall cell lung cancer patients now have a 50 percent chance of surviving for more than five years. Stage 3 with mediastinal node involvement limited to the ipsilateral chest and completely resected has a 20 percent five-year survival rate. These results are achieved only with prompt diagnosis and treatment. Endoscopy is essential in the preoperative work-up and must be done by the operating surgeon. Planning incisions, sleeve resections, and assessment of the remainder of the lung are facts the surgeon must have first-hand. Needless repetition of endoscopies can be avoided if referral is made promptly when the diagnosis of lung carcinoma is strongly suspected. A biopsy specimen obtained in the operating room can be confirmed from frozen section in minutes. Five or nine biopsies are unnecessary!

We hope to maintain and even to improve the present survival rates for lung carcinoma, combined efforts by all physicians who see and treat these patients is needed.

The greatest beneficiary in this interdisciplinary approach will be the person who counts the most—the patient.

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REFERENCES


Regression of Left Ventricular Hypertrophy after Intervention?

Cardiac hypertrophy implies an increase in the muscle mass of the heart associated with an enlargement of some muscle fibers. As echocardiography (echo) allows direct measurements of free ventricular wall thickness, it is not surprising that echo has proven to be more reliable than ECG in diagnosing ventricular hypertrophy. In the January issue of Chest, (83:56-62) Cueto-Garcia and associates report regression in left ventricular mass (LV mass) and left ventricular wall thickness (LVWT) 3 to 66 weeks after...