operated on to get the diagnosis by frozen section in a few minutes by having a thoracotomy? If the answer, after undertaking a thoracotomy, comes back small cell carcinoma of perhaps a lymphoma, I assume the chest is then closed and the patient has benefited little from all that has been done. Transbronchial biopsy by an appropriately trained specialist would have avoided all the unnecessary procedures and risks mentioned above. In my experience, it is not uncommon even for large lesions not to be seen by routine endoscopy, but yet they can be reached fairly easily transbronchially under fluoroscopy.

I heartily concur with Dr. McCormack that repetitive bronchoscopic examinations are fruitless, but I do think that bronchoscopy should be repeated under fluoroscopic control or in fact done that way initially to try and obtain a diagnosis before the patient is taken to the operating room. I think a surgeon needs to know the bronchial anatomy for planning any resection prior to surgery. If I perform a bronchoscopic procedure that shows cancer and refer the patient to a surgeon, I try to define as accurately as possible the extent of abnormal bronchial anatomy. I feel I am qualified to describe this fairly accurately. Nevertheless, I would very much welcome the surgeon performing re-bronchoscopic examination at the time of the surgery if he feels it is necessary to have an actual personal view of the bronchial anatomy. I might add that this has seldom been done, in my experience.

I do not agree with Dr. McCormack that the thoracic surgeon is the only one or even the best one to carry out this diagnostic procedure.

William A. Byron, Jr., M.D.
Indianapolis

To the Editor:

Dr. McCormack's statement that "preoperative bronchoscopy must be done by the operating surgeon, thus avoiding needless repetition of endoscopies" deserves comment from pulmonary internists. Physicians knowledgeable in lung cancer realize that initial staging of endoscopically visible lung cancer often reveals inoperability, thus eliminating the need for surgical consultation. Operable cases can be adequately described, thus eliminating the need for endoscopic repetition. In addition, I doubt that any physician would depend upon a frozen section of a bronchoscopic biopsy specimen for definitive diagnosis to determine operability, i.e., permanent section would have to be made available.

One can also compare both cost effectiveness and morbidity in bronchoscopy performed under local anesthesia with minimal assistance from auxiliary staff with bronchoscopy performed in an operating room, often with general anesthesia and assistance from operating room nurses and their supporting cast. Dr. McCormack and her references (all thoracic surgeons) may indeed have an inaccurate and self-interested viewpoint.

Bruce E. Sherling, M.D., F.C.C.P.
Mamaroneck, New York

In our Pathology Department, frozen section diagnosis is 95 percent reliable. It has been our experience, as stated in reference 3, that our bronchoscopic findings differ as much as 71 percent of the time from reported findings in patients referred. Our referral base is very broad and this may explain the discrepancy.

I have no objection to anyone doing transbronchial biopsy (and Dr. Byron and I know several of us surgeons who are trained in the art). I speak from an experience of receiving referrals too late to achieve the best results for the patients, and if I have cut down on lag time at all, it will be worth it.

In response to Dr. Share's comments, my recommendation for prompt therapy means within as short a time as possible, not beyond one month, if possible. Again, the point as to who should perform the endoscopy must be made by the physician seeing the patient first. An obvious candidate for a surgical approach benefits from prompt referral, just as a patient coming to my office with interstitial problems is promptly referred to a pulmonologist.

Stage 3 lung cancers with N2 disease are always treated by us with combined surgery and irradiation. The best results, as published by Martini, have been unmatched by any other approach and the one patient in four or five who can have at least an additional five good years of living should be given the opportunity to opt for this choice of treatment.

Patricia McCormack, M.D.
New York City

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Patient's Wife Cures His Snoring

Editor's note: The following communication was submitted to Chest by one of our physician-readers. He received it from a patient. A member of the Editorial Board who reviewed the comments noted "the contents of this letter may well prove to be useful for family harmony!"

Dear Doctor:

In regard to my husband's sleep apnea-snoring problem, after we talked to you, I invented a method to prevent my husband from sleeping on his back. I sewed a pocket into the back of a T-shirt and inserted a hollow, lightweight plastic ball (about the size of a tennis ball). I fastened one side of the pocket with safety pins so that the ball can be removed to launder the shirt.

It's working beautifully. In about two days, I could see a vast improvement in his energy level, alertness, and interest in life. He no longer falls asleep while sitting straight up in a chair, and the quiet, snoreless nights are great!

I thought this information might be helpful to other patients with a similar problem.

Exercise-induced ST Segment Alternans

To the Editor:

We read with interest the report of Wayne, Bishop and Spodick (Chest 1983; 83:824) concerning exercise-induced ST segment alternans. We would like to comment upon and, hopefully, clarify several points. We are aware of at least four other similar reports.1-4 It is, in our opinion, a false assumption to infer that because a finding occurs during exercise it cannot be due to coronary artery spasm. It is well described that Prinzmetal's angina can occur during exercise testing.5 A similar case which we reported6 underwent two additional