Communications to the Editor

Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Specific permission to publish should be cited in a covering letter or appended as a postscript.

Bronchoscopy for Bronchogenic Carcinoma

To the Editor:

I would like to address two errors and three areas of controversy in Dr. McCormack’s recent editorial (Chest 1983; 83:838). The results of the papers of Popovich et al1 and by me2 were incorrectly stated. Popovich et al found that four biopsies of an endobronchial lesion provided the best diagnostic yield, while we found the probability of a positive diagnosis to be .9877 after two biopsies and .9966 after three.

I agree with Dr. McCormack that prompt diagnosis and therapy are important, but I disagree with the implied definition of “prompt,” that is, diagnosis and surgical therapy at the same setting. While the capability to obtain a rapid diagnosis by frozen section is convenient, it is not essential. A one- or two-day hiatus while awaiting interpretation of fixed tissue specimens is acceptable and, for many patients, desirable. Many patients wish to use this time to order their affairs prior to surgery or to consider therapeutic options, particularly in cases of stage 3 disease.

I also disagree that the initial diagnostic bronchoscopic examination must be performed by a surgeon. Bronchoscopy should be performed by a competent endoscopist, whether internist or surgeon. In addition to obtaining a diagnosis of the primary lesion, the endoscopist should be able accurately to assess the endobronchial proximal extent of disease for staging. Endobronchial staging is particularly important, since many patients, unfortunately, present with advanced, unresectable disease. The extent of disease can often be determined endoscopically, and such patients need not be seen by the surgeon. In fact, of the 445 patients with stage 3 disease reviewed by Martini et al3 and cited by Dr. McCormack, 46 percent were considered inoperable at diagnosis because of several factors, including tracheal metastases, malignant pleural effusions, oat cell carcinoma, and medical contraindications to surgery. Thus, a large number of patients will not require surgical resection.

Finally, despite the results of Martini et al,3 the utility of surgery for stage 3 disease is not clearly established. The 20 percent three-year survival reported in this series reflects the results of surgery (resection and mediastinal node dissection) and postoperative radiation, not the results of surgery alone, as implied by McCormack. In addition, similar results can be found with other treatment modalities. Eagan et al4 found a 23 percent three-year survival with a combination of radiation and chemotherapy. Aristizabal and Caldwell5 found a 19 percent three-year survival in limited stage 3 disease with radiation alone in patients with well-differentiated tumors. These results indicate that the best therapeutic approach to stage 3 disease is not clear at this time. While surgery combined with some adjuvant therapy is promising, other forms of therapy may achieve similar results. Current and future studies need to consider a variety of prognostic factors such as patient performance status, tumor type, and degree of tumor differentiation before a clearer picture can emerge.

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References


To the Editor:

I find Dr. McCormack’s comments in her editorial very confusing. The question she tries to answer is: which specialist should most appropriately perform the diagnostic test in a given situation, and I assume she is referring to fiberoptic bronchoscopy. Her answer to this question is difficult for me to accept.

The gist of her conclusion seems to be that the thoracic surgeon in the operating room is the specialist who should perform the procedure. Her reasoning is that a biopsy specimen obtained in the operating room can be confirmed with in a few minutes. If Dr. McCormack is implying that the patient is anesthetized (and I assume that they are anesthetized since she says they are in the operating room), then is the appropriate treatment (immediate surgery?) undertaken? If so, suppose the diagnosis turns out to be small cell carcinoma. Then I assume no operation is undertaken and the patient has been put through the risk of general anesthesia for nothing. If the patient is in the operating room, but is not anesthetized, is then the bronchoscopic procedure carried out and then if the answer comes back cancer, is the patient then immediately put to sleep and the surgery undertaken at that time?

Also, how does one know that a tumor is endoscopically visible unless one actually performs an endoscopic procedure? Suppose the lesion is not endoscopically visible? One, then, has a patient under general anesthesia, but cannot see a tumor and therefore what does one do at this point? Is transbronchial biopsy then attempted? I know of no thoracic surgeon trained to perform this fluoroscopically guided procedure in the operating room. Or is the patient then
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 to 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. Shure’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.

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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.4-7 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.8 A similar case which we reported7 underwent two additional