performing TBNA prior to these procedures. In addition, Dr. Wang has stated that "the interpretation of a positive TBNA in patients who lack roentgenographic evidence of mediastinal disease represents a still more difficult problem, and further experience is necessary to clarify the significance of this finding." We suggest that some of these patients may have false-positive TBNA secondary to "contamination" by aspirated endobronchial secretions.

We are concerned about the potential false positive TBNA, and therefore, have incorporated surgical staging (cervical or parasternal exploration, and mediastinal exploration at thoracotomy) in all patients in our study, regardless of TBNA results, to better assess the specificity of this technique. We feel it is premature to withhold surgical staging in many patients who demonstrate malignant cytology (non-small cell carcinoma) via TBNA. It is hoped that our study will better delineate the specificity of a positive TBNA.

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Freedman et al can’t possibly be serious! If they are serious, they have completely overlooked the fact that FEV₁ abnormalities are highly predictive of premature morbidity and mortality from chronic obstructive pulmonary disease and that those with abnormality who stop smoking have a better outcome than those who continue (Peto et al. Am Rev Respir Dis 1983; 128:491-500). They must really be pulling our leg by being negative about spirometry because they completely left out the fact that the forced vital capacity was one of the best predictors of survival, including deaths from all causes in the Framingham study (Kanner et al. Tr Am Life Ins Med Dir 1980; 64:66-81). They continue to dwell on the small airways business and here they are right because no one really knows whether tests of small airways dysfunction are relevant to clinically significant COPD or not, although answers to this question will be forthcoming. They also completely omit the fact that knowledge of early pulmonary function abnormalities can be motivating factors in smoking cessation as recent studies have strongly suggested. Finally, they are excessive in their estimates of cost, since simple spirometric tests for FVC and FEV₁ are commercially available for $5.00 in many parts of this country. Isn’t it worth at least $5.00 to be informed about prognosis for COPD and indeed prognosis for life?

In response, Macklem, who continues to be a mild opponent of the use of spirometry in screening, makes strong arguments for the use of spirometry in physicians’ offices for clinical purposes. Thus, an expert who is often blamed for retarding programs in the early identification and intervention of COPD (and other lung diseases) now argues eloquently for the widespread use of spirometry in clinical practice!

Thus, Freedman and colleagues become the classic “straight man” in the typical Abbott and Costello routine, “Who’s on first?, What’s on second? and I don’t know on third.” An analogy to the routine in the old movie could be the present “players” in this comic routine who can be likened to patients seen in the doctor’s office. “Who” is that person destined to premature morbidity and mortality from emerging chronic lung disease; “who” later becomes the patient requiring pulmonary rehabilitation techniques, home oxygen therapy, management of acute respiratory failure in intensive care units and/or home oxygen therapy. “What” could be likened to the 500,000 Social Security disability receipts alone, if all these advanced patients are placed on home oxygen at an approximate cost of $4,000 per year. This would cost $2 billion on oxygen services alone, to say nothing of the physician’s fees, hospitalizations and intensive care unit stays. I’ll leave this argument there.

“I don’t know” is the physician sitting in his office wondering whether or not his coughing-smoking patient could be developing early stages of chronic airflow limitation as a prelude to emerging chronic obstructive pulmonary disease. This same physician has 20 to 30 years available in order to intervene through smoking cessation and perhaps other pharmacologic manipulations.

Therefore, as one who has had some concerns about the problem of COPD and the lack of interest in the widespread use of spirometric testing for reasons which have never been explained, I spilled my morning cup of coffee all over my March issue of Chest from laughing so hard!

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To the Editor:

While our colleague was laughing violently, spilling coffee on our article and recalling with obvious pleasure his memories of watching Abbott and Costello routines, he apparently missed the gist of our

“Stage Prop” Humor

To the Editor:

A recent commentary by Freedman et al (Chest 1984; 85:406-07), argued that screening for early stages of chronic obstructive pulmonary disease would cost this country at least $500 million and the likelihood of any benefit to large numbers of persons identified with early abnormalities would be small. Macklem’s response in the dialogue in the March issue of Chest came forward with resounding arguments that spirometry is as necessary to the practice of medicine as the sphygmomanometer and the clinical thermometer. Thus, the stage is set for laughter!
Breathing and Feeding

To the Editor:

We were perplexed by Dr. Koretz's editorial (Chest 1984; 85:298). He stated that employing nutritional support in the patient on mechanical ventilation seems to be illogical until prospective randomized clinical trials (PRCT) document the efficacy of this type of therapy.

It was surprising to see a physician with his background advocating the return of the "good old days" of dextrose and water diet. We would like to know Dr. Koretz's suggestions on managing patients who are receiving mechanical ventilation without what he calls "artificial system of nutritional support." Perhaps his conclusions are directed at those patients who are well nourished, with an uncomplicated, short illness, and who are expected to be able to take oral feeding in a few days. Unfortunately, these are not the typical respiratory failure patients on mechanical ventilation seen in a multidisciplinary tertiary care intensive care unit. Most frequently, these patients are malnourished, septic and/or with some kind of trauma, whose caloric expenditure is well above normal. Many of these respiratory failure patients are not able to eat for weeks or even months, leaving us with the choice of either feeding them by enteral or parenteral means using these "artificial types of nutrition" or allowing them to die from the complications of malnutrition and starvation.

It is true that well-nourished eumetabolic patients, requiring mechanical ventilation for only a short period, can manage to survive with only water and electrolytes supplied by the peripheral vein route. Furthermore, we agree with the fact that "artificial" feeding, like other types of therapy, is abused and can cause a myriad of complications. Nevertheless, human beings have known since the beginning of their existence that they must eat in order to survive and that fasting cannot be prolonged indefinitely. To reach this conclusion, PRCT are unnecessary. Experiments done in the early 1800s demonstrated that dogs could live on meat, but died when fed sugar and water alone. Nutrition has been ignored in hospitalized patients in the past. We wonder when the medical community will accept nutrition as credible.

For the above reasons, clinical experience, and the result of non-PRCT, we feel every potentially salvable individual on ventilatory support who is also hypermetabolic or malnourished or expected to have this form of respiratory therapy for weeks or months should receive a proper caloric/protein intake with the requirement of electrolytes, vitamins, and trace elements until PRCT show that patients can live indefinitely on mechanical ventilation without nutrients.

This type of therapy should be applied by a properly trained physician in order to minimize complications.

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To the Editor:

No one, not even I, would argue that humans (or any other living organism) can live indefinitely without nutrients. Patients on respirators are usually placed on such devices because of ventilatory, not nutritional, failure. Such respiratory assistance is employed for limited periods of time, be it days, weeks, or months.

Drs. Teba, Dedhia, and Schiebel raise an important issue, nonetheless. How long is too long to go without nutrition? They note that well-nourished eumetabolic patients can tolerate short periods of ventilation with only intravenous fluids. I agree with this conclusion. Likewise, it would seem reasonable to all four of us that a patient who is on the respirator for "months" is a candidate for nutritional support. This latter situation is relatively uncommon. In the three papers cited, only seven of 73 patients (10 percent) were