Is This Physician Really a Specialist?

It is January 5, 1990 and my patient is going to spend a few months in the Sun Belt. I wish him to be observed by a pulmonologist during this interval, and, depending upon his symptoms, there may be a need for cardiovascular consultation. Where can I obtain authoritative information on the credentials of physicians in the area in which my patient will reside?

I could refer to the American Medical Association Directory, but this provides no information on the location or extent of training in the specialties of medicine. It does not list certification in a subspecialty, and thus, there is no way to distinguish between "the self-styled cardiologist with board certification in internal medicine alone, and the cardiologist who has board certification in that sub-specialty."

For inclusion in the AMA Directory, physicians are asked to designate their areas of specialty on the basis of number of hours devoted to that area. "This self-designated, unverified information about specialty is included in the Directory...and appears to carry the imprimatur of the AMA."

Having failed to verify the credentials of physicians in this way, I could then turn to the Marquis Directory of Medical Specialists compiled for the American Board of Medical Specialties. However, there are a significant number of specialists who have not agreed to be listed in this Directory and there is another group who decline to supply any biographic data, including information on their training. Finally, and most important, "The group that is listed and does supply biographical information does so without any objective verification. The descriptions of residency and fellowship training come from the physicians, and not from hospitals and medical schools."

Though the two sources noted above offer more useful information than the citations listed in the Yellow Pages of the telephone directory, it is evident that there is an urgent need for comprehensive information on the status of physicians based upon objective verification.

Recognizing these inadequacies, the American College of Chest Physicians, several years ago, undertook to do something about it then...at least for the cardiopulmonary-specialist members of the ACCP.

The resulting ACCP Membership Directory and Referral Guide is a 900-plus page storehouse of information about over 14,000 ACCP members. Education, specialty training, board certification and current status are clearly and completely shown in the city-by-city geographic listing.

Additionally, a unique section categorizes the entries by specialty, so that it takes only a moment to find pulmonary specialists in Omaha, cardiologists in Miami, cardiovascular surgeons in Toronto. Because the world is growing smaller, these listings also extend to Paris and Sydney, Buenos Aires and Tokyo, Haifa and Belgrade.

The ACCP takes great pride in its stringent requirements for Fellowship. Those who are granted that deservedly respected Fellowship certificate have been thoroughly vetted. Their training and certification have been verified, their standing in the medical community attested by their peers. Their subsequent listing in the Directory is evidence of the high regard in which they are held by their colleagues.

In an often-confusing milieu, the ACCP Membership Directory and Referral Guide is an all-too-rare example of a truly useful reference source. The names listed are those of the best in the cardiopulmonary and allied specialties; the data shown for each are informative...and verified!

We think our pride is pardonable.

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REFERENCE

1 Reade JM, Ratzan RM. Access to information—physicians' credentials and where you can't find them. N Engl J Med 1989; 321:466-68

Anaerobic Pleuropulmonary Infection

This issue of Chest (see page 69) contains an interesting article by Peña Griñán and colleagues in which 50 patients with lung abscess underwent percutaneous lung aspiration for bacteriologic studies and cytology. This raises the question as to when this procedure may be indicated in the non-study situation.

The bacteriology of anaerobic pulmonary infections
(pneumonitis, necrotizing pneumonia, lung abscess and/or empyema) has been studied extensively, although additional studies are certainly indicated now in view of the advances that have been made in anaerobic bacteriology (use of anaerobic chambers, prereduced media, new selective media, newly described organisms, etc) and significant changes in taxonomy of the anaerobes. The study cited, however, adds nothing to available information. Elements of the normal oropharyngeal flora are the key pathogens in community-acquired disease. Anaerobes (Gram-negative rods [various Bacteroides, Porphyromonas and Fusobacterium species] and Gram-positive cocci [Peptostreptococcus]) and viridans group streptococci predominate. The B fragilis group is found in 7 percent of such infections and other beta-lactamase producing anaerobes are more common. In hospital-acquired aspiration pneumonia, nosocomial pathogens that colonize hospitalized patients may be involved in infection along with the organisms noted above; included would be Staphylococcus aureus, various Enterobacteriaceae, and Pseudomonas aeruginosa.

In view of the resistant bacteria that may be encountered at times, it would seem desirable to obtain definitive bacteriologic studies in patients who are quite ill, especially those with necrotizing pneumonia. There are reasons to hesitate to do this, however—the difficulty in obtaining reliable specimens, the time required to perform these studies, and the cost. Since the source of the infecting organisms in these patients is almost always the upper airways, the specimen must be collected so as to avoid indigenous and colonizing organisms. To culture delicate anaerobes, the specimen must be placed under anaerobic conditions promptly; this is difficult with certain procedures used to obtain specimens. Empyema fluid provides a reliable specimen in sufficient volume so that it can be placed into an anaerobic transport vial or tube. Transtracheal aspiration, when not contraindicated, is this writer’s choice when empyema fluid is not available. Percutaneous transthoracic aspiration typically provides a very small specimen. In the study cited above, however, the authors attached a syringe to the sampling needle and obtained specimens of good volume; use of a transport vial might have improved the results, even with a short transport period. The above technique would not yield sufficient specimen in infections other than lung abscess. The telescoping plugged double catheter technique using a bronchial brush as the sampling device results in a tiny specimen that is difficult to place under anaerobic conditions promptly. Experience with quantitative culture of bronchoalveolar lavage fluid is limited. The time and cost issues can be averted by assuming that resistant anaerobes are present, and treated accordingly (or by assuming they are not in patients who are not very ill and changing to more potent therapy if the response is not adequate); culture for aerobic and facultative bacteria only will yield results quickly and cheaply; the issue of specimen collection remains an important one.

As to therapy, the primary approach is use of antimicrobial agents, except in patients with empyema, who require drainage procedures. Open drainage with rib resection and breakdown of loculations may be required in advanced, refractory cases. Initial antimicrobial therapy should be empiric, based on the usual bacteriology encountered, whether or not the infection is hospital-acquired, susceptibility patterns of nosocomial pathogens from the hospital involved, prior therapy that may have led to selection of antibiotic-resistant strains, and information from Gram stain of a reliable sputum or other appropriate specimen. Therapy can then be modified as needed, based on the patient’s response and information obtained in the first 18-24 hours from cultures. Drugs essentially always active against anaerobes include imipenem, ticarcillin/clavulanate, ampicillin/sulbactam, metronidazole plus penicillin, and chloramphenicol. The first three agents listed are generally active vs S aureus except for the methicillin-resistant type; they (particularly the first two) also have significant activity against Gram-negative non-anaerobic rods. Cefoxitin and clindamycin are quite active against most anaerobes; addition of penicillin would be helpful in the case of clindamycin. Penicillin G, itself, is still useful in many patients with anaerobic pulmonary infection, but should not be used as sole therapy in patients who are quite ill. These various suggested regimens for the anaerobic component of the infecting flora should be supplemented, as indicated, to cover other types of organisms known or anticipated to be present.

As to cytologic studies, this writer would favor bronchoscopy as the definitive procedure.

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