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: Enough or Not Enough?

To the Editor:

I am responding to the editorials by Drs. Rohwedder, Sen and Walsh. In minimizing the need for fiberoptic bronchoscopy as a proper and often vital procedure to help mobilize tenacious, inspissated sputum in patients with pneumonia and COPD, doctors underestimate the large role that sputum plugs play in the morbidity and mortality of these diseases. Retained sputum is often difficult to diagnose clinically, and atelectasis represents only the tip of the iceberg. Derenne, in his recent state-of-the-art review of COPD, states that: "Bronchoscopies performed in course of 28 patients with moderately severe ARF [secondary to COPD] have shown the presence of pus in the airways in nearly all the cases..." Patients suffer chronically and quietly with recurrent infections and debilitation. They require repeated, prolonged hospitalizations and treatment with recurrent or chronic regimens of steroids. They are more prone to require ventilatory support, and weaning from ventilators is difficult.

To label bronchoscopic attempts at improving the devastating impact of retained sputum as "overzealous" is unfortunate. These patients often cannot adequately mobilize molasses-like sputum with conservative measures such as percussion and postural drainage. Sometimes they improve partially, but have chronic pulmonary impairment subsequent to discharge from the hospital. Fiberoptic bronchoscopy allows for the assessment of retained sputum—there just is no other way to do it. When sputum plugs are found, they are removed.

The authors quote Hippocrates' caveat to "do no harm" gratuitously. Patients suffering from pneumonia and COPD come to the pulmonologist for relief of severe illness. Withholding FFB, a low morbidity procedure, when there is reasonable clinical suspicion that the patient has retained secretions after conservative measures have failed to adequately help, is unfair to the patient.

By implying that financial incentives play a role in the decision-making of the pulmonologist, the authors impugn and trivialize the efforts of these doctors' earnest efforts to help these large numbers of patients who just do not do well otherwise. I have been in the clinical practice of pulmonary medicine for over 15 years and can state unequivocally that retained sputum is often missed, that conservative therapy often does not work and that removing sputum plugs often results in marked and long lasting improvement. FFB is actually cost-effective by shortening the severity, length and frequency of illness.

Lastly, I am afraid I disagree when the authors call bronchoscopy a science. It is really just a procedure. Neither is the clinical practice of pulmonary disease a science, as much as we wish it were so. Because of the difficulty in assessing and treating patients with COPD and pneumonia (who make up the bulk of the practice of clinical pulmonologists), the daily practice of pulmonary medicine is as much an art as a science. One aspect of the art is when to decide to use the bronchoscope.

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REFERENCES


To the Editor:

We respect the conviction with which Dr. Stangel holds his beliefs and his experience, yet we cannot agree with his position. On the surface, Dr. Stangel's approach may seem good—early bronchoscopy in respiratory failure and chronic obstructive pulmonary disease (COPD) detecting viscous or mucopurulent secretions, with removal resulting in "a more benign clinical course: sparing patients from chronic ventilatory support or death, shortening hospitalization, and (in outpatients) decreasing their chronic need for steroids and frequent absences from work. We stand behind our initial reply in which we acknowledge that in selected patients with refractory atelectasis (we think the operational word is refractory because most patients respond to conventional treatment), physiologic (improved oxygenation and compliance) and clinical benefits may sometimes be realized. We also reiterate our anecdotal successes and failure with bronchoscopy in this setting. It is far from universally effective. We do not stand alone in this opinion. Olopade and Prakash have recently published their experience with bronchoscopy in the critical care unit. First, they found it to be safe, with minor complications occurring in less than 10 percent of patients. During 90 therapeutic procedures, they noted substantial mucous plugs or nonoccluding thick secretions in 37 (41 percent), but detected (objective) roentgenographic improvement or improvement in gas exchange following bronchoscopy in only 17 (19 percent). We concur with their conclusion: "the safety of flexible fiberoptic bronchoscopy is no indication for routine use of this procedure for retained secretions."

Dr. Stangel's contention that regular removal of "retained secretions" from patients with COPD enhances their quality and duration of life is unsubstantiated and misleading. Prospective assessment of 2,718 British men demonstrating long-term mortality from COPD was closely linked to airflow obstruction but not mucous hypersecretion, when corrected for airflow obstruction.

We agree with the statement of Derenne and colleagues that "acute respiratory failure of patients with COPD does not call for a single approach to treatment." Although he and his colleagues report frequently finding secretions within airways, they also state that, when indicated, "assisted or controlled ventilation allows rapid improvement of gas exchange and easy suction of secretions."
Utility of Echocardiography in AIDS

To the Editor:

We have read with great interest the paper by Hecht et al in which they present the results of a study designed to evaluate the frequency of unsuspected cardiac abnormalities in acquired immunodeficiency syndrome (AIDS). This prompted us to report our results obtained performing M-mode and two dimensional echocardiograms on all AIDS patients admitted for treatment of any AIDS-associated tumor or infections complication.

We have evaluated 40 patients (27 drug abusers, nine homosexuals and four promiscuous heterosexuals) whose ages ranged from 23 to 30 years (mean 29 years). All fulfilled the CDC criteria for AIDS. We investigated the global incidence of cardiac abnormalities independent of the presence of cardiac symptoms or other evidence of cardiac disease.

In the group of intravenous drug abusers (27 cases), we found tricuspid vegetations in three, tricuspid regurgitation in three, pericardial effusion in three (minimal in two and severe in one, in whom it was secondary to M tuberculosis), severe left ventricular disfunction (LVD) associated with moderate pericardial effusion in one, and moderate ventricular hypokinesia in another. Only one of these two patients with echocardiographic evidence of LVD was symptomatic. He had a pericardial effusion which was secondary to M avium-intracellulare infection, as previously reported in another case. 2

In the homosexual group (nine patients), we found only one patient with LVD. This also was the only case with clinical manifestations in this group. No other abnormalities were found. Over the remaining studied patients (four heterosexuals), no echocardiographic abnormalities were found. In summary, LVD, pericardial effusion, regurgitation or vegetations were detected in 12 of 40 AIDS patients (30 percent).

Our data suggest that echocardiographic findings in AIDS patients correlate well with clinical symptomatology or physical examination data. The other unsuspected echocardiographic findings are unrelant to the present clinical status and do not provide useful additional information for clinical care. Only occasional cases (one of 40) have asymptomatic ventricular dysfunction. So the indication for performing an echocardiogram in AIDS patients must always be established on clinical data, at least in the drug abuser population. In this group, pericardial disease is frequently due to mycobacterial infection. When additional homosexual patients are evaluated, we will be able to establish if we have the same frequency of asymptomatic echocardiographic abnormalities as found by Hecht et al in this group.

To the Editor:

We read Dr. Romeu's letter with interest, but disagree with several of his points. We do not feel that the findings of tricuspid vegetations or regurgitation should be included in the overall incidence of echocardiographic abnormalities in the AIDS patients. These findings can be attributable to intravenous drug usage alone and should be excluded from analysis.

The incidence of left ventricular dysfunction reported in this study is lower than that found in our study and in others. Since the completion of our study, the incidence of echocardiographic abnormalities noted in AIDS patients in our laboratory continues to be high. The reason for the lower rate found by Dr. Romeu is not clear, but perhaps is due to random variation and will increase when additional patients undergo echocardiographic examination.

We do not advocate the routine use of echocardiography in all AIDS patients, and agree that the test should be performed when clinically indicated. However, we disagree with his assertion that this information is clinically irrelevant. As new therapies are developed for AIDS and life expectancy increases, these cardiac abnormalities will probably play an increasing role in morbidity, and possibly mortality, in this relatively young group of patients.

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REFERENCES