exchange abnormalities, although it is quite likely that they are rarely diagnosed in this setting due to clinician bias (which is as yet not supported by data).

Given that the true sensitivity and specificity of arterial blood gas testing and Vd/Vt analysis has not been determined in a design where all entered patients are evaluated until a diagnostic study either confirms or excludes the diagnosis, I do not believe that either can be used to exclude pulmonary embolism. Because of the prevalence of intrinsic lung disease and resultant gas exchange abnormalities, and potentially the development of abnormal spirometry as a consequence of vasoactive mediators of pulmonary embolism, I am unconvincing that the combination of Vd/Vt and spirometry will justify its expense in the routine clinical evaluation of pulmonary embolism.

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Multiple Endobronchial Metastases due to Renal Carcinoma and Laser Therapy

To the Editor:

I found the report by Carlin et al (Chest 1989; 96:1110) concerning endobronchial metastases due to colorectal carcinoma and their Nd:Yag laser debulking therapy very interesting. I also agree that Nd:Yag laser debulking, in combination with external beam radiation therapy (XRT) and endobronchial radiation therapy, may afford an improved survival in selected patients with impending total airway obstruction.

I recently encountered a 46-year-old Japanese man with right renal carcinoma associated with multiple endobronchial metastases (left B4, right B6 and basal bronchus). The patient underwent a right radical nephrectomy with partial resection of the inferior vena cava plus lymphadenectomy in June, 1981. Fifty-seven months later, follow-up chest roentgenogram revealed an abnormal shadow at the left hilum and a mild obstructive pneumonia. Bronchoscopic examinations revealed obstruction of the lingular bronchus (B6) due to endobronchial metastases (Fig, upper left). TBLB specimens revealed metastatic lung cancer (clear cell renal carcinoma). The patient immediately underwent left upper lobectomy. Sixteen months later, follow-up bronchoscopic examination revealed a partial obstruction (85 percent) of the right B6 bronchus due to endobronchial metastases (clear cell renal carcinoma) (Figure, upper right). After bronchoscopic Nd:Yag laser debulking therapy (total 4,500 J) and XRT (total 5,000 cGy), obstruction of the B6 bronchus was much improved but other endobronchial metastases in the right basal bronchus appeared (Fig, lower). Although further laser therapy

Figure. Bronchoscopic examination performed in February, 1986 revealed endobronchial metastases at the left lingular orifice (upper left). Bronchoscopic examination performed in September, 1987 revealed endobronchial metastases at the right B6 bronchial orifice (upper right). Bronchoscopic examination performed after Nd:Yag laser therapy and XRT revealed a marked reduction of endobronchial metastases at the right B6 but other endobronchial metastases in the right basal bronchial orifice (b, lower).
(total 6,300 J) against the basal bronchial endobronchial metastases was continued, the patient died of respiratory failure 27 months after the appearance of endobronchial metastases at the right B bronchial orifice. These results suggest that Nd:Yag laser debulking therapy led to the relief of symptoms and a survival period of up to 27 months.

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Treatment of Spontaneous Pneumothorax

To the Editor:

I disagree with the conclusions of O'Rourke and Yee in their article on the treatment of spontaneous pneumothorax. I believe that observation is often appropriate and that immediate chest tube thoracostomy or thoracotomy unnecessarily prolongs hospital stay and increases patient discomfort. An older paper—which is similar to O'Rourke and Yee's study in design, number and age of patients, and concurrent illness—supports the use of observation as initial treatment of a spontaneous pneumothorax. However, neither study was prospective or randomized, so conclusions can only reflect the authors' opinions. I suspect that the therapeutic modalities used in both studies reflected the training and bias of the attending physician rather than to the actual need for a chest tube or thoracotomy.

Treatment of patients with pneumothorax should be individualized depending on the clinical circumstances, but observation is still the appropriate course of action in many cases. In fact, O'Rourke and Yee state that 18 percent of patients in their observation group eventually needed a chest tube. In other words, 82 percent of these patients did well without any intervention. I wonder how many of the patients in the other treatment groups would have done well with observation alone?

More aggressive modes of therapy (such as aspiration, chest tube thoracostomy or aspiration) may be needed, but should be reserved for patients with unresolved or recurrent pneumothorax, or in patients with poor pulmonary reserve in whom a pneumothorax would be dangerous.

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REFERENCES


To the Editor:

I agree with Dr. Liss that, because our study was retrospective, physician bias will certainly affect the choice of therapeutic options offered for the treatment of spontaneous pneumothorax. However, the great majority of patients in our study were admitted to and initially treated by nonsurgeons. Surgical consultation was obtained when therapeutic intervention was requested.

Dr. Liss is incorrect in his interpretation of our using "immediate" thoracotomy for the treatment of SP. As clearly stated in our paper, thoracotomy was only considered for treating ipsilateral recurrence, bilateral occurrence, and failure to resolve a pleural leak (greater than seven days' duration) with chest tube thoracostomy alone. We and others have found that thoracotomy with pleural abrasion or pleurectomy is the best modality to prevent recurrent pneumothorax. In our opinion, it is better for these patients to undergo definitive thoracotomy rather than suffer the morbidity of treating multiple recurrences with chest tubes and observation.

Although Dr. Liss is correct in pointing out that the majority (82 percent) of our patients in the observation group did well and did not require intervention during that hospitalization, we would again emphasize that there were two deaths in this treatment group and none in the other groups. This underscores the danger of allowing an unrecognized open pneumothorax to rapidly progress to a tension pneumothorax and sudden death. Although this may be a rare event, certainly any death from this easily treatable disease is a tragedy.

A good alternative would be attempted aspiration of the pneumothorax using one of the disposable kits now available. A follow-up chest x-ray film taken immediately and several hours later can confirm the existence of a closed or open pneumothorax that will need insertion of a chest tube. This would fulfill three goals: hospitalization can be shortened, re-expansion of the lung can be achieved, and the dangerous existence of an open pneumothorax can be recognized.

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REFERENCE


Enticements for Fruitless Bronchoscopy

To the Editor:

The recent editorial by Dr. Bohwedeer (Chest 1989; 96:708-10), "Enticements for Fruitless Bronchoscopy" should serve as a beacon of common sense for those of us concerned with the rising cost of healthcare in this country. Although data is not available to document the overuse of FOB in the community, one does not need the services of a weatherman to determine that a torrential rainstorm is in our midst and no end is in sight from the downpour. The facts concerning flagrant overuse of endoscopy are unequivocal, but who is to blame? Are the teaching hospitals not providing the proper training necessary to make these clinical decisions? Have the ATS and ACCP neglected their constituency by not providing appropriate guidelines for standard of care? Are there too many pulmonary physicians in the community competing for survival? Or have our internal medicine and surgical colleagues been deluded by the false presumption that fiberoptic bronchoscopy can diagnose and treat all the pulmonary abnormalities they face in their daily practice? Perhaps it is a combination of all of the above or perhaps it is the bogey man of defensive medicine—the malpractice suit—which perpetuates the excesses.

Whatever the cause for the overuse of fiberoptic bronchoscopy in clinical medicine, curbing the incessant rise does not appear a likely