pleuroscopy "over conventional means of diagnosis is unclear" is virtually impossible to draw from the paper of Fauschou et al. Pleuroscopy deserves, indeed, more attention. Since 1910, pleuroscopy has been widely used, mainly in Europe, as a diagnostic and therapeutic procedure. Its diagnostic yield in pleural effusion is close to 100 percent. Pleuroscopy is usually performed with the use of local anesthesia and, although it requires hospitalization, has several advantages over closed pleural biopsy: (1) It allows examination of the pleural cavity, including the costal pleura, the diaphragmatic dome, the cardiophrenic and costophrenic angles, the lung surface and fissural aspects of the lobes, and the mediastinal pleura. (2) Pleural biopsies can be taken at multiple sites under visual control. (3) Lung biopsies can be taken easily. (4) Infiltration of sclerosing agents for chemical pleurodesis can be done at the end of the procedure if a frozen-section biopsy yields a positive result for malignancy. Complications of pleuroscopy, such as subcutaneous emphysema, shortness of breath, and arrhythmias, are observed in less than 10 percent of the patients. Mortality is minimal: only one death was found in a review of approximately 8,000 diagnostic pleuroscopic procedures.

We believe that, if the same diseases can cause both symptomatic and asymptomatic pleural effusions (as Smyrnios et al concluded), a more active diagnostic workup should be established, especially to rule out malignancy and tuberculosis. Therefore, pleuroscopy—which is clearly superior to repeated pleural fluid cytology and blind pleural biopsys—should be considered when a thoracentesis with closed pleural biopsy has not been diagnostic and the probable cause of the effusion is not clinically apparent.

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To the Editor:

We read with interest the letter by Rami-Porta et al concerning the limited discussion of pleuroscopy in our recent special report on the evaluation of asymptomatic pleural effusion. Our bias in favor of a second closed biopsy stems from our own limited experience with pleuroscopy and the less-than-definitive literature on the comparative usefulness of pleuroscopy. We disagree with the statement that pleuroscopy has been "widely used" since 1910. Most studies of pleuroscopy are retrospective in which the diagnostic yields of thoracoscopy and closed pleural biopsy have not been compared with pleuroscopy in a formal way. However, Boutin et al employed a more systematic analysis of the sensitivity of these different methods and found that pleuroscopy resulted in 84 percent positive results in 75 patients with malignant pleural effusion who had three previous negative cytologic and two previous negative needle biopsy results.

There is little doubt that the procedure can be useful for some indications, as noted by Rami-Porta et al. To these we would also add its use to avoid unnecessary thoracotomy and when tube thoracostomy will be required anyway. On the other hand, negative aspects of pleuroscopy include the need for an average hospitalization of three to four days, which is an important consideration these days. General anesthesia is used by some advocates, with its associated risk. There is also the morbidity associated with the need for prolonged chest tube drainage after the procedure. Complications reported include hemorrhage, subcutaneous emphysema, bronchopleural fistula, tumor seeding, persistent pneumothorax, and death. However, the frequency of complications is less than that seen with open pleural biopsy or open lung biopsy, a point in favor of pleuroscopy.

We agree that the use of pleuroscopy in select cases with local anesthesia can be helpful in evaluating the cause of pleural effusion. A more widespread role can be defined only by prospective studies comparing its risks and benefits with those of other diagnostic studies.

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Occurrence of Mitral Valve Prolapse in Nonsmoker Spontaneous Pneumothorax Patients

To the Editor:

Margaliot et al found mitral valve prolapse (MVP) in 11 of 22 (50 percent) patients who suffered spontaneous pneumothorax (SP) but in only 10 percent (four of 40) of the control subjects. They concluded that the excessive occurrence of MVP is the first documented proof of connective tissue disease, an underlying factor in the development of SP.

They presented no data on smoking habits for either the SP patients or the control subjects.

Smoking has statistically been shown to increase the risk of contracting SP. For this reason, we studied the occurrence of MVP in ten SP patients who had never smoked, with the same method. These patients were randomly selected from the group of SP patients who had never smoked and who were treated/controlled at the Department of Pulmonary Medicine, Huddinge University Hospital, in 1980-1989. The diagnosis of MVP could be established in one patient.

This finding may complete the data presented by Margaliot et al and suggests that smoking may have some role in the hitherto unclarified pathogenetic mechanism of MVP.

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REFERENCES


Tracheobronchial Stents and Fiberoptic Bronchoscopy

To the Editor:

We read with interest the article by Dumon (Chest 1990; 97:329-33), regarding a specific tracheobronchial stent. The author states that "insertion requires rigid bronchoscopy with the patient under general anesthesia."

Recently, we had the opportunity of inserting one of these prostheses designed by Dumon using a fiberoptic bronchoscope (FB). A 42-year-old man with a large-cell undifferentiated carcinoma of the right upper lobe and extrinsic compression of the bronchus intermedius underwent explorative thoracotomy. In the following postoperative days, he required bronchoscopic toilet repeated because of recurrent atelectasis of the right lower and middle lobes, causing respiratory insufficiency. We decided to insert a stent in the bronchus intermedius. This maneuver was performed by means of an FB and with use of local anesthesia. The respiratory symptoms were relieved with complete resolution of the atelectasis within 48 h. Three months later the patient's general state was satisfactory with excellent tolerance of the prosthesis.

The insertion technique is simple. The FB (Fujinon BRO-Y-25) is in effect sheathed within the "pusher tube" (a flexible, plastic, 45-50-cm-long tube of the same diameter as the prosthesis to be inserted), leaving the last few centimeters free for the stent to be placed in such a way as to leave the FB totally covered by both tubes. The FB is introduced, sheathed as already described, and the stent is placed orally in the chosen site with direct visual control. This done, we remove both the FB and the "pusher tube," confirming the correct placement of the stent and achievement of the intended solution.

The most extensive experience with these stents until now does not report the placement of this kind of prosthesis by means of an FB and with standard local anesthesia. Although this technique can be applied only in certain cases and with small stents, using the above method makes this operation not only efficient but also easier, quicker, and practically risk free.

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REFERENCE


Erratum

To the Editor:

We have a correction for our article "The Spectrum of Tuberculosis in a New York City Men's Shelter Clinic (1982-1988)" (Chest 1990; 97:798-805). The figure provided for the annual rate of cases of active tuberculosis for this population during the period study was incorrect. The correct rate is 875/100,000.

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