Mathisen, a general thoracic surgeon (as I have been for some years), was greatly disturbed about nonsurgeons doing percutaneous tracheostomies—and not doing them in the operating room! And doing them in the intensive care unit, at the bedside—and with the patient under local anesthesia!

He justifiably points out that “new techniques must be judged on merit by their safety, ease of performance, cost-effectiveness, and stand the test of time...” We also agree with his statement that “a meticulous tracheostomy performed under optimal conditions and carefully attended to postoperatively should be associated with few complications.” Agreed! But the same is true of a properly performed percutaneous dilatational tracheostomy done with the patient under local anesthesia in the intensive care unit. Reports supporting this opinion¹ have appeared.

Dr Mathisen is also worried, justifiably, about complications in the long run. It takes time to collect enough cases with long-term follow-up data to present an adequate number. The senior author of this letter (F.C.P.) reported the first percutaneous dilatational tracheostomies in 1985 in Chest,² but my associate and I have waited until now to collect enough cases with long-term follow-up. We reported on 105 patients in a paper delivered in part in Toronto at the 56th Annual Scientific Assembly of the American College of Chest Physicians³; the full paper will be submitted for publication. Our long-term clinical follow-up on decannulated patients shows no evidence of any complications.

There are now modern subspecialists, such as critical care specialists, intensivists, pulmonologists, interventional radiologists, and invasive cardiologists, who do many percutaneous and endoscopic procedures. They implant permanent cardiac pacemakers, drain abscesses percutaneously, do percutaneous angioplasties, endoscopically remove polyps of the colon, and perform many other procedures that surgeons did in the past by open operations.

Thirty years ago, the senior author of this letter had to open the chest wide in order to put his hands in the pleural cavity and then had to place his finger in the left atrium to open a stenotic mitral valve. Today, when indicated, a balloon is inserted percutaneously through the venous system and then through the atrial septum to dilate the stenotic valve. This is done by a nonsurgical specialist!

The editorial writer displays some undue “turf” arrogance when he states that “indications for tracheostomy may be broadened, thereby performing tracheostomy when not appropriate. Many intensive care units are run by nonsurgical specialists. They cannot be expected to have the historic perspective of the results of emergency tracheostomy and what surgical precautions are now taken to ensure the fewest complications possible.” Since when does a surgeon decide when a critically ill medical patient needs an elective tracheostomy? Isn’t the pulmonologist or the intensivist or the critical care specialist who is attending the patient competent to decide when it is time to go from a translaryngeal tube to tracheostomy? These subspecialists are certainly as good as, if not better than, any surgeon at making this particular decision. And they are doing it all the time.

In addition, these nonsurgical specialists will be the judges as to whether their patients who undergo percutaneous dilatational tracheostomy done under local anesthesia in the intensive care unit do as well as, or better than, the patients operated on in the surgical suite. And if these nonsurgeons decide to do the procedure themselves, after proper preparation and credentialing, there is enough turf for two (or more) specialties.

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REFERENCES

Fiberoptic Bronchoscopy without Premedication

To the Editor:

We read with interest the report by Colt and Morris,¹ which appeared in the December 1990 issue of Chest. It was reassuring to note that despite premedication, many elderly patients did not have a higher complication rate when compared with those who did not receive any premedications.

However, we were surprised when the authors concluded: “Decreased facility fees, reduced medication and personnel costs and decreased observation requirements should lead to decreased expenditures without compromising patient care, safety or comfort.” This retrospective study did not evaluate or report on patient comfort. The level of cooperation was also not measured. In a British study,² patient cooperation and comfort were examined by asking patients to answer a few questions after each bronchoscopic examination. While the authors concluded that flexible bronchoscopy can be performed without any preoperative sedation, seven of the 100 patients received diazepam, 10 mg, intramuscularly before the procedure. Thirteen other patients described discomfort or displeasure. Rees et al.³ evaluated the level of discomfort during 60 bronchoscopic procedures and observed that 26 of 60 (43 percent) experienced significant discomfort during fiberoptic bronchoscopy. Most patients found the passage of the scope through the larynx to be the most difficult part of the procedure.

In community hospitals, where a significant percentage of the patients are female, we wonder how the patient’s comfort and cooperation will not be compromised without some preoperative medications.⁴ How many of these patients will give a consent for a second flexible bronchoscopic examination if the first was performed without appropriate sedation? Some postoperative observation and/ or follow-up will be required even if the patient did not receive preoperative medication. Hence, the cost saving will be minimal. More important, we believe that the question of cost and safety must be assessed along with patient comfort and optimum cooperation. Good patient care must include patient comfort as well as cost and safety.

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To the Editor:

The comments by Dr Mehta and Dr Stubbs are welcome, and we emphasize again the diverse opinions regarding preparation for fiberoptic bronchoscopy with the patient under local anesthesia. We agree that maximum comfort and cooperation must be ensured for patients undergoing invasive procedures. This element could not be precisely assessed because of the retrospective nature of our study. After 20 years of experience, however, we have not been impressed by the effects of "routine premedication" on patient comfort and cooperation regardless of age, sex, or indication. No patient has refused a second bronchoscopic procedure when informed of the necessity. We suspect that confident reassurance, kind and considerate nursing care, and a gentle, experienced endoscopist contribute significantly to a smooth procedure. Coping mechanisms are probably important as well, and may differ in regard to sex, age, race, or nationality. Prospective studies that focus on these multiple facets and compare them with premedication alone may be desirable.

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Chronic Cough

Sometimes You Have to Look at a Tree to See the Forest

To the Editor:

In the January 1991 issue of Chest, Drs Sen and Walsh expended considerable effort to demonstrate the diagnostic yield of fiberoptic bronchoscopy (FB) in a select group of chronic coughers and concluded that, "in patients refractory to therapy based on clinical evaluation, FB may have a significant diagnostic yield." However, 72 percent (18/25) of their patients are left with an undefined cause for their chronic cough. This is significant when compared with the findings in a recent report by Poe et al., in which no diagnosis was arrived at for 20 percent (16/78) of their patients with negative results on a provocative airway challenge study. Typically, these patients are labeled with a diagnosis of exclusion, such as "psychogenic cough" or malingering.

We speculate that a significant number of these patients who present with chronic cough and/or dyspnea on exertion have laryngeal dyskinesia (LD). This is an ill-defined syndrome that is characterized by paradoxical adduction of the vocal cords during inspiration. Laryngeal dyskinesia is reported to mimic asthmatic exacerbations, but may also present with milder symptomatology, such as chronic cough. Sen and Walsh reported the case of one patient with an abnormal flow-volume loop who was later found at bronchoscopy to have LD.1

Over the past two years, we have evaluated six patients with unexplained cough or wheezing and found five of them to have LD. In each case, pulmonary function studies and methacholine chal-

lenge testing failed to reveal an obstructive ventilatory pattern. Two patients with LD had normal flow-volume loops at rest. In each patient, bronchoscopy showed paradox adduction of the vocal cords during inspiration, either at rest or after an exercise challenge that reproduced their symptoms.

In our evaluation of chronic cough, we utilize the anatomic diagnostic protocol. It is important to separate pulmonary from nonpulmonary causes of cough and differentiate upper airway from lower airway disease to initiate the appropriate therapy. Patients with LD would be expected to have a negative result on a methacholine challenge study and, in some cases, a normal flow-volume loop. Therefore, it is critical to include the evaluation of the upper airway and vocal cords during bronchoscopy as part of the anatomic diagnostic protocol to diagnose LD.

We believe that milder forms of LD are responsible for the symptoms of chronic cough in more patients than has been previously recognized. Indirect laryngoscopy may be inadequate to diagnose LD, and these patients have indications for both a lower and an upper airway examination. Therapy for patients with LD concentrates on speech and psychotherapy at the present time. We are prospectively evaluating patients with chronic cough to determine the actual incidence of LD in this patient population.

Laryngeal dyskinesia may be poorly recognized because many bronchoscopists, in their haste to "rule out an endobronchial lesion," bypass appropriate vocal cord evaluation. Bronchoscopic training should include a careful examination of the upper airway and dynamic vocal cord movement. We must be vigilant during bronchoscopy to perform evaluation of both the upper and the lower airways, and be able to recognize a tree before we characterize the forest.

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Coronary Arterial Spasm and Cardiac Arrest following Mediastinal Radiation Therapy for Hodgkin's Disease

To the Editor:

Coronary artery disease following high-dose radiation therapy for Hodgkin's disease has been previously reported. We report the case of a patient who presented with episodes of angina associated