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.

Communications to the Editor

Cytostatic Activity of Pulmonary Alveolar Macrophages in Lung Cancer Patients

To the Editor:

I read with interest the article by McDonald and Atkins,1 which appeared in the October 1990 issue of Chest. The authors reported that the baseline cytostatic activity of pulmonary alveolar macrophages (PAMs) in patients with cancer is lower than that in controls and that the PAM abnormality is part of a generalized immune defect in lung cancer and does not simply reflect a local response to the carcinoma. However, whether antitumor activity of PAMs is augmented or suppressed in lung cancer patients is still controversial. In 1987, we published an article on that subject.2 In this study, PAMs from tumor-bearing and non-tumor-bearing segments were obtained separately by the lavage of bronchoalveolar tracts of resected lungs of 74 patients with primary lung cancer. The cytostatic activity (CTs) of PAMs obtained from non-tumor-bearing segments was stable in spite of enlargement of tumor size or progression of N factor. In contrast, the CTs of PAMs obtained from tumor-bearing segments may be augmented at stage II as compared with stage I, and suppressed with an advance of stage from II through IV, although the number of stage II patients was as small as three. Moreover, the CTs of PAMs from tumor-bearing segments was suppressed in N2 as compared with N0 and N1; also, it was suppressed as compared with that of PAMs from non-tumor-bearing segments in N2 disease. The CTs of PAMs from smokers was suppressed compared with the CTs of PAMs from nonsmokers in both tumor-bearing and non-tumor-bearing segments. On the basis of these results, we believe that lung cancer cells or their products may suppress antitumor activity of PAMs in tumor-bearing segments at advanced stages, and that cigarette smoking is suppressive of antitumor activity of PAMs.

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REFERENCES


Rapid Percutaneous Tracheostomy

To the Editor:

I read with great trepidation the article by Schachner et al., which appeared in the November 1990 issue of Chest. The authors have developed a method for rapid tracheostomy to be used in emergency or mass casualty situations, as well as electively. The procedure involves hyperextending the neck and inserting the tube, utilizing a guide wire technique, between the second and third tracheal rings. Being intimately involved in the acute care of trauma victims, as well as chronically ventilated critically ill patients, and having had personal experience with the technique described, I think several points need to be addressed.

Stauffer and colleagues,3 in a prospective study of complications and consequences of endotracheal intubation and tracheostomy, concluded that complications are frequent and severe and the mechanisms of laryngotraheal injury are "complex and probably multifactorial." Thus, complications related to excessive cuff pressure requirements, self-extubations, inability to seal the airway, agitation with frequent head movement, and nutritional status still remain unaddressed by the authors. Undoubtedly, local surgical skill and expertise in airway management are fundamentally dependent variables in the risk of morbidity after tracheostomy. Stock and colleagues,4 in a prospective study of 81 patients, noted no major perioperative complications and a 6 percent incidence of minor complications from tracheostomies performed in the intensive care unit by a defined cadre of surgeons with proficient skills. Other recent retrospective studies5 support this finding.

For patients who require emergency surgical airway access, cricothyroidotomy is a well-accepted procedure. The risk of subglottic stenosis appears significant only in patients with acute laryngeal pathology. The technique described by Simon et al.6 utilizing the hyoid bone, is useful for the patient with massive neck swelling.

I have serious reservations about the technique described by Schachner et al.7 First, the authors performed the procedure with hyperextension of the neck, a maneuver that is contraindicated in the blunt trauma victim without prior cervical spine clearance. Second, palpation of the third tracheal ring is possible only in lean patients. Third, I have found that the jaws of the tracheostome are extremely sharp and often lacerate the cuff, necessitating availability of another cuffed tube. Fourth, the tube accompanying the tracheostomy kit is very pliable, making insertion difficult. Schachner et al admit to a number of limitations (eg, in patients with bull neck, large tumors of the neck, or extensive edema of the subcutaneous tissues). Based on personal experience, I agree with them. Clearly, this technique needs to be tailored to select individuals and certainly not used on acute blunt trauma victims. Unfortunately, it seems best suited to the lean patient with a long, thin neck, the type of patient in whom the ease of conventional tracheostomy renders the technique unnecessary.

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