Long-term Oxygen Therapy
When to Leave Well Enough Alone

Long-term home oxygen therapy is now clearly established as the "standard of care" for selected patients with COPD and chronic stable hypoxemia. In fact, oxygen is the only therapy for advanced COPD that has been proved to add substantially to the length and quality of life.1-5

Walter O'Donohue's observations on the restorative effect of oxygen6 are important. He showed that gas exchange improves in some patients after they have received home oxygen therapy for several months. The mechanism is likely to be a reduction of both bronchospasm and pulmonary vasospasm as known responses to oxygen, which in turn probably improves ventilation-perfusion matching and thus the elevated oxygen tension while breathing air.

The argument that further oxygen may no longer be necessary in patients who demonstrate this improvement is absolutely astonishing. Why should we make nature repeat its life-threatening experiment of reactive pulmonary hypertension, erythrocytosis, and global deterioration in patients with advanced COPD? In fact, observations of improved oxygenation may predict a favorable outcome, since the reverse (ie, deteriorating arterial oxygenation following the initiation of oxygen therapy) is a poor prognostic indicator.7

We should not have to constantly requalify patients for reimbursement for their necessary oxygen if it was originally appropriately prescribed after a period of stabilization therapy. We don't stop insulin in diabetics under control, discontinue antiarrhythmic agents in patients with previous ventricular tachycardia, or discontinue systemic and antihypertensive drugs in advanced and complex hypertensive conditions. No, a huge body of evidence has established oxygen as the key treatment in advanced stages of COPD, when chronic stable hypoxemia is present and where there is evidence of harm from pulmonary hypertension, erythrocytosis, or general deterioration.

Too bad we don't do better in the early stages, when smoking cessation could obviate the need for oxygen several decades down the line. We should leave well enough alone when oxygen produces major physiologic benefits, and concentrate our efforts on making this life-saving therapy unnecessary.

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References
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Clinical Utility of Thoracoscopy

Lewis and co-workers present their preliminary experience with thoracoscopy as a method to obtain lung biopsy specimens in this issue of Chest (see page 60). Although there has been a worldwide resurgence of interest in thoracoscopy as a diagnostic and therapeutic tool, a renewed interest in thoracoscopy in the United States has occurred only recently. The brief article by Lewis and co-workers describes the feasibility of obtaining lung biopsy specimens by thoracoscopy, and the data suggest its possible utility as an alternative to open-lung biopsy for obtaining adequate amounts of lung tissue in the diagnosis of diffuse lung disease. As a result of improving endoscopic optics and video imaging technology, thoracoscopy affords the opportunity to provide unique diagnostic and therapeutic approaches to patients with pleural and lung parenchymal disorders. To appreciate the poten-