As noted in an editorial1 in the July 1992 issue of Chest, "there has been a worldwide resurgence of interest in thoracoscopy as a diagnostic and therapeutic tool.” Much of this intense interest is the result of improving endoscopic optics and video imaging technology.

Should this technique be limited to thoracic surgeons, or may it be used safely and appropriately by pulmonologists (ie, nonsurgical specialists)? If nonsurgeons are sanctioned to perform thoracoscopy, should there be specific limitations? That is, should there be developed detailed ground rules for specific indications and contraindications for thoracoscopy? If so, who should develop these rules?

Our editorial office has received a large number of thoughtful letters presenting views on the issues cited above. In this issue and in the months to come, we plan to present communications identifying these concerns. We stress that these letters should not be interpreted as representing the views of the officers of the American College of Chest Physicians or the Editorial Board of Chest. This international forum is presented solely for the purpose of offering a sounding board for representative viewpoints of our multidisciplinary constituency.

Alfred Soffer, M.D., F.C.C.P.
Editor-in-Chief

Reference

To the Editor:

Dr. Ketan Mehta and I have been performing thoracoscopy here in Santa Rosa, California, for the past year, with experience of about 30 cases. These all have been appropriately evaluated previously with thoracentesis and blind pleural biopsy, as well as chest x-ray films and computed tomographic scans. The workups have historically all been nondiagnostic until thoracoscopy could be performed, at which time diagnosis was established in the majority of cases and effective therapy and appropriate pleurodesis were undertaken.

The procedure technically is not much more difficult than placement of a chest tube. Of course, the training and experience of pulmonologists vary depending upon their local environment and the skills and interests of the thoracic surgeons. If pulmonologists are comfortable with a wide variety of intensive care unit work, however, there should be no reason why thoracoscopy could not be an appropriate tool for use diagnostically and therapeutically.

I urge your organization to develop guidelines for thoracoscopy and to issue a position paper indicating that pulmonologists, with appropriate training, may perform thoracoscopy.

I also urge you to initiate a training course for pulmonologists in the practical aspects of thoracoscopy. Not to do so will needlessly deprive pulmonologists of an excellent opportunity to establish diagnoses and initiate therapy on patients without the needless misery of formal thoracotomy. Leaving the procedure to the discretion of thoracic surgeons will not advance the goals of pulmonary medicine or serve the best interests of our patients.

Eugene Belogorsky, M.D.
(Pulmonary Medicine)
Santa Rosa, California

The editorial by Mathur and Martin was well written and informative, but was still disturbing. Although the authors state that many thoracoscopic procedures will fall exclusively under the purview of the thoracic surgeon, I interpret that they also consider the performance of thoracoscopy by physicians who are not thoracic surgeons appropriate under some circumstances. This is an unfortunate direction to be taking. The “Statement of the AATS/STS Joint Committee on Thoracoscopy and Video Assisted Thoracic Surgery”1 states that these procedures “should only be performed by thoracic surgeons who are qualified, through documented training and experience, to perform open thoracic surgical procedures and manage their potential complications.” A small incision carries the same potential for catastrophe in the thorax as a large one. In the event that physicians who are not thoracic surgeons are credentialed for, and begin performing, thoracoscopy, I have no doubt that there
will be any number of unneeded complications and mortalities.

Daniel P. Harley, M.D., F.C.C.P.,
Chief, Thoracic Surgery,
Franklin Square Hospital Center,
Baltimore

REFERENCE

To the Editor:

I do believe that there is enough difference in anatomy and in potential complications between fiberoptic bronchoscopy and thoracoscopy that it should be acknowledged that a physician performing a thoracoscopy should have the ability to do an open procedure and "fix" potential complications.

I should also note for the record that in my years as a young staff physician, after pulmonary training, we did thoracoscopy using the fiberoptic bronchoscope. I found this procedure to be quite cumbersome, and subsequent studies indicated that examination of a large volume of fluid for cytology would achieve the same diagnostic efficiency in terms of underlying malignancy. Based on this experience, I decided not to continue to perform this procedure.

I believe that rigid thoracoscopy, using newer instruments and techniques, is an excellent procedure, and that there is reason to limit this procedure to thoracic surgeons.

Douglas W. Jenkins, M.D., F.C.C.P.
(Pulmonary Diseases)
San Antonio, Texas

To the Editor:

I am writing you in the hope that the American Thoracic Society and the American College of Chest Physicians will take a position in support of thoracoscopy as a procedure that can be safely performed by adequately trained pulmonologists. There is overwhelming evidence that thoracoscopy can be done safely and effectively by physicians who are not thoracic surgeons.

A recent statement from the AATS/STS newsletter states that only thoracic surgeons should perform a thoracoscopy because of the potential need for an open surgical procedure. The literature does not support this concern. Furthermore, if surgical backups were necessary, this would be similar to the well-established protocols used by cardiologists who perform percutaneous transluminal coronary angioplasty with surgical backup.

I agree that the thoracoscopic procedure as utilized by pulmonologists should initially be restricted to pleural biopsy, pleurodesis, and treatment of empyema. However, peripheral nodules and parenchymal biopsies are being performed safely, in addition to laser and cautery coagulation of small leaking blebs. Large parenchymal biopsies requiring stapling or extensive cautery should be reserved for the thoracic surgeon.

The parietal pleura and pleural space have long been the domain of the pulmonologist. The risks and diagnostic yield of transthoracic Cope needle biopsy make this procedure obsolete in comparison to thoracoscopic pleural biopsy. At the very least, a pulmonologist who is proficient in chest-tube placement and management should be entitled to acquire the skills necessary to perform thoracoscopic procedures involving the parietal pleura and the pleural space.

Douglas W. Kane, M.D., and
James O. Shaw, Jr., M.D., F.C.C.P.,
Peninsula Pulmonary Associates,
Newport News, Virginia

To the Editor:

I am writing in support of the position that pulmonologists should not be precluded from performing thoracoscopy. I, too, am frustrated by a certain void in the technique in blind pleural biopsy and cytologic examinations of pleural fluid. I certainly would appreciate the opportunity to directly view, and obtain biopsy specimens from, tissue that is ultimately found to be pathological. This certainly is an area where medical management can preclude the involvement of yet another physician—that is, a surgeon whose further involvement would not otherwise be necessary. It is also noteworthy that adequately trained gastroenterologists probably perform laparoscopic procedures as well as general surgeons.

With these thoughts in mind, I endorse the performance of thoracoscopic procedures by internists/pulmonologists. However, I think that this is an opportunity for both the American Thoracic Society and the American College of Chest Physicians to assume responsibility in providing adequate guidelines for performing these procedures. Certainly, a trainee should have performed an adequate number of procedures to allow the development of clinical competence in various situations. Furthermore, an ongoing case load should be documented to verify continued competence and further reduction of morbidity in the hands of that individual.

I would envision a specific training interval that would exceed 72 h. Perhaps a 6-month rotation of a