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.

Thoracoscopy Forum: Continuing Dialogue

To the Editor:

I am sure that you are well aware that thoracoscopy has a long history and was originally a procedure commonly performed by internists in the prechemotherapy era of tuberculosis therapy. This has been a well-accepted procedure in Europe for a number of years, and some of the most respected thoracoscopists are internists. I recently had the pleasure of meeting Dr. Christian Boutin of Marseilles and Dr. Robert Lodenkemper of Berlin. These gentlemen are pulmonologists and have a vast experience in thoracoscopy, and both have published excellent texts on the subject. They both encouraged me to develop a program for thoracoscopy to be performed by pulmonologists at my institution.

I personally believe that there is a role for pulmonologists in performing diagnostic thoracoscopy. Most pulmonologists, including myself, have no designs on performing video-assisted thoracic surgery, but I do feel there is a role for pulmonologists in performing thoracoscopy for diagnosis and management of pleural diseases.

There was a similar concern approximately 10 years ago, when there was some feeling that laser bronchoscopy was too dangerous for pulmonologists to perform. Time has shown this not to be the case, and in fact at this point the most respected laser bronchoscopists in this country are pulmonologists. I suspect that if the College could help develop guidelines that better define diagnostic thoracoscopy and video-assisted thoracic surgery, some of the fears that our surgical colleagues may have concerning pulmonologists performing thoracic surgery can be alleviated.

Thank you for your concern in this matter.

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Section of Pulmonary and Critical Care Medicine,
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To the Editor:

I am a practitioner of pulmonary and critical care medicine (board-certified in both areas) who has for many years performed invasive bronchoscopy and percutaneous needle biopsies of the pleura (among many other invasive procedures). At bronchoscopy I often perform transbronchial biopsies and Wang-needle biopsies. In addition, I do both diagnostic and therapeutic percutaneous catheter drainage of pleural effusions, and, in emergencies, I place chest tubes.

Under the circumstances, I fail to see how diagnostic thoracoscopy performed by a trained pulmonologist (who is trained and experienced in the procedure) would be intrinsically more dangerous to the patient than these other procedures. I do believe that the performance of such procedures is better suited to a hospital that has on-site coverage by a qualified thoracic surgeon.

I urge your organization to issue a statement regarding the use of this procedure by trained pulmonologists and, if appropriate, to perhaps define suggested guidelines for such use.

This would also be an excellent topic for discussion at the next national meeting.

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(Pulmonary Disease and Critical Care Medicine)
Bristol, Tennessee

To the Editor:

I have recently learned that the thoracic surgeons are trying to restrict the performance of thoracoscopy exclusively to thoracic surgeons. While some thoracoscopic procedures are certainly in the domain of thoracic surgery, there are other procedures that are being performed with a high degree of success and safety by pulmonologists. At the Medical College of Virginia, two of our pulmonary faculty have been performing thoracoscopy for more than 5 years with no significant complications. We use the technique to inspect and obtain biopsy specimens from the parietal pleura, primarily in cases of undiagnosed pleural effusion. Our procedure is performed with local anesthesia (and intravenous sedation only if necessary) in our procedure room.

Thoracoscopy is rapidly taking over as the preferred route for many thoracic surgical procedures involving mediastinal and pulmonary structures, procedures that are clearly the domain of the operating room and the thoracic surgeon. However, the present move to restrict all thoracoscopy to thoracic surgeons is not justified as it will restrict the availability of thoracoscopic evaluation of parietal pleural lesions and dramatically increase the expense, since the surgeons' fees, anesthesiology fees, and operating room expenses cost about the same as a full thoracotomy. Our charges are similar to those for bronchoscopy.

At our institution we have a thoracic surgeon doing thoracoscopy and two pulmonologists also doing thoracoscopy. The surgeon does a full range of operative procedures on the lung and mediastinum, and the pulmonologists stick to the parietal pleura. Our system works fine, and I would encourage the American College of Chest Physicians to advocate this cooperative and cost-efficient parallel development of thoracoscopy practice.

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To the Editor:

I have observed a consulting thoracic surgeon perform thoracoscopic biopsies and have witnessed one situation in which a "simple" wedge resection was complicated by massive blood loss due to cross-sectioning of a pulmonary arteriole. Had the surgeon not been able to rapidly intervene by "crushing" the chest, this patient would not have had an uneventful recovery.