Communications to the Editor

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.

John F. Beams, Jr., M.D., F.C.C.P.,
Section of Pulmonary and Critical Care Medicine,
Lahey Clinic Medical Center,
Burlington, Massachusetts

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.

John G. Byers, Jr., M.D., F.C.C.P.
(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 thorascopic 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 including 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 endoscopic 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.

Kevin R. Cooper, M.D., F.C.C.P.,
Division of Pulmonary and Critical Care Medicine,
Medical College of Virginia,
Richmond

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 "crashing" the chest, this patient would not have had an uneventful recovery.

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To the Editor:

I would like to categorically oppose the use of this procedure by pulmonologists who are not versed in thoracic surgery.

R. William Corwin, M.D., F.C.C.P.
(Pulmonary Disease and Critical Care Medicine) Providence, Rhode Island

To the Editor:

At Mercy Hospital and Medical Center here in San Diego, where I am the Medical Director of Respiratory Care, several of my colleagues in pulmonary medicine have taken postgraduate courses and are embarking on performing diagnostic thoracoscopy.

I remember attending a course about 15 years ago, and while it was intriguing, I never quite saw a wide enough application in my own practice to persevere. Times have changed, however, and I believe it is important that the American College of Chest Physicians encourage pulmonologists throughout the country to take up this useful procedure.

Further, I believe it is well within the capability of a competently trained pulmonary physician to perform. It is another example of procedures that have previously been in the realm of thoracic surgeons now becoming part of pulmonary medicine as well.

I believe that the practicing pulmonary physician has a lot to offer patients with undiagnosed pleural effusions by using thoracoscopy, and that our professional organizations should support this.

Kevin P. Glynn, M.D., F.C.C.P.
Division of Respiratory Care
Mercy Hospital and Medical Center, San Diego

To the Editor:

I attended a course given by Long Beach Memorial Hospital, which was taught by Christian Boutin and Yo Aekony, as well as others who have performed thousands of thorascopies and are themselves pulmonologists. There was a thoracic surgeon also speaking at the meeting, and he reiterated his belief that thoracic surgeons alone should be allowed to perform this procedure. This was not at all the sentiment of Dr. Boutin or the other speakers.

I myself work at Mercy Hospital in San Diego, and we are in the process of trying to establish thoracoscopy as a diagnostic tool for the pulmonologists. As you might guess, there is a great deal of resistance on the part of the thoracic surgeons. Their arguments are for the most part spurious and self-serving. I have attended several thorascopies performed by a thoracic surgeon, and I have found my presence in the operating room invaluable (since this was for the most part a diagnostic procedure) and have on more than one occasion limited the size and extent of the incision performed.

I appreciate the effort that you are making to mobilize the community of pulmonologists, and I am sure that with time the medical community as a whole, and patients in particular, will come to realize that having their diagnostic workup performed by one person who thinks it through is ultimately in their best interest.

Lucien N. Jassy, M.D., F.C.C.P.
(Pulmonary Disease) San Diego

To the Editor:

It is quite apparent that many pulmonologists place chest tubes, as do general practitioners. This has been acceptable practice, and I would think it would be unrealistic to attempt to restrict chest tube placement to thoracic or general surgeons. In the same fashion, it would appear that thoracoscopy is a procedure that could indeed be performed by qualified nonsurgical physicians. I do think that care would have to be exercised in the training of such physicians, but I do not believe that the procedure by itself necessitates the ability to immediately perform a thoracotomy.

At the current time, it is apparent that the American Association for Thoracic Surgery and the Society of Thoracic Surgeons are recommending that this procedure be restricted to thoracic surgeons only. I believe that this is unnecessarily limited. It would be a more acceptable position if the procedure were limited to physicians who have been adequately trained in the procedure. The setting up of some type of a credentialing process for this procedure would, I think, be the best outcome for patients and medical care in general, rather than defining who can do it on the basis of professional subspecialty.

Your attention to this matter is appreciated.

William D. Lucht, M.D., F.C.C.P.
(Pulmonary Disease and Critical Care Medicine) Halstead, Kansas

Hydatidosis with Pericardial Involvement

To the Editor:

We read with great interest the case report of Mandke and Sanyogiri, which appeared in the April 1991 issue of Chest. We report here a case of systemic hydatidosis involving the abdominal as well as the thoracic visera, such as the left lung, pleura, and pericardium. Such extensive hydatidosis is very rare.

A 25-year-old farmer was admitted to the hospital with cough, expectoration, weight loss, and thoracic pain. The sputum was mucopurulent. There was no history of hydatid fluid expectoration. The chest x-ray film revealed cardiomegaly and homogeneous opacity in the lower and middle regions of the left lung. Echocardiography showed minimal pericardial effusion and hypertrophy of the left ventricle. Computed tomography revealed multiple cysts near the aortic arch, in the paracardiac and paravertebral regions, on the thoracic wall, and in the upper portion of the abdomen, which shifted the spleen (Fig 1). There was no bronchial spread in

Figure 1. Computed tomogram reveals multiple cysts near the aortic arch, in the paracardiac and paravertebral regions, on the thoracic wall, and in the upper portion of the abdomen.

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