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 13 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. Glynis, 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 thoracoscopies 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 thoracoscopies 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 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 Sangiri, 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 viscera, 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.](image-url)