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.

Who Should Perform Thoracoscopy? The Controversy Continues

To the Editor:

Money is, unfortunately, one of the obsessive goals of modernity. Nevertheless, ethics about money are frequently easy to understand. As a symbol, let me introduce them in a deeper context: the controversy about who—pulmonologists, thoracic surgeons, general surgeons, or even gynecologists—should perform thoracoscopic surgery.

Let us imagine a purely private practice—that is, one in which costs and fees are directly paid by the patients. Who would then pay for the complication of a thoracoscopic procedure carried out by a clinician who needs a surgeon to reoperate on his patient? Would the pneumonologist charge to his own account the surgeon's fees and the hospital bill? Would the surgeon work for free? Or would the patient be overcharged for the cost of the complication?

In our country, surgeons usually do not charge additional fees for reoperations due to their own surgical complications. What can be done when the procedure has been performed by someone who cannot handle the complication?

Personally, I think that the wisest advice is the classic, "Do not get involved in procedures the complications of which you cannot solve by yourself."

Hugo Esteva, M.D., F.C.C.P.,
Hospital de Clínicas "Jose de San Martin,"
Buenos Aires, Argentina

Systemic Capillary Leak Syndrome

To the Editor:

Systemic capillary leak syndrome (SCLS) is a very rare idiopathic disease characterized by hypotension, hemococoncentration, generalized edema, and an IgG paraprotein. Despite aggressive resuscitation and prophylactic treatments, this syndrome is often fatal. We report the case of a patient in whom a possible adenoma may have had a pathophysiological role in this syndrome.

A 36-year-old man was admitted with symptoms including nausea, vomiting, weakness, oliguria, and low back discomfort. He was hypotensive, requiring a total of 11 L of intravenous fluids to control the hypotension. His pretherapy hemoglobin level was 23 mg/100 ml with a hematocrit of 67 percent. Endocrinologic evaluation was normal. Immunologic testing showed an IgG kappa paraprotein and normal levels of complements, C1q inhibitor, autoantibodies, histamine release assays, immune complexes, cryoglobulins, and serum histamine. A bone marrow aspirate was normal. His urine did not contain free light chains or monoclonal protein.

Over the next 64 days, there were 14 similar episodes. Skin biopsy specimens showed a minimal, nonspecific chronic perivascular mononuclear infiltrate. Immunofluorescence studies were negative. A muscle biopsy showed no histopathologic abnormalities.

REFERENCES

2 Swierenga J, Wagenaar JPM, Bergstein PGM. The value of thoracoscopy in the diagnosis and treatment of diseases affecting the pleura and lung. Pneumologie 1974; 151:11-8
3 Kapsenberg PD. Thoracoscopic lung biopsy under visual control. Poemun Coeur 1981; 37:313-16