Communication 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."

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To the Editor:

In the editorial by Mathur and Martin,1 which appeared in the July 1992 issue of Chest, the authors stated that there has been a worldwide resurgence of interest in thoracoscopy as a diagnostic and therapeutic tool. This is only partly true. In many European countries, like France, Germany, Spain, and The Netherlands, thoracoscopy has been routinely performed by pulmonologists since the 1960s, which has resulted in many articles giving evidence of a vast experience.2,3 Severe complications making thoractomy (and the help of a surgeon) necessary hardly ever occurred.

For many years now, pulmonary fellows in training hospitals in our country have learned how to perform thoracoscopic under local anesthesia in the bronchoscopy room, and thoracoscopy belongs to the everyday practice of a pulmonologist in our country. The most important indications are recurrent spontaneous pneumothorax and pleural effusion. However, many pulmonologists are also experienced in obtaining thoracoscopic lung and pleural biopsy speci-

mens.4-8 Until recently, surgeons in our country were not even interested in this procedure. In our opinion, there is no reason why thoracoscopy should not be performed by pulmonologists. Creating training facilities for pulmonary fellows might broaden the scope of pulmonologists in the United States.

Nevertheless, it is of prime importance that anyone who starts to learn thoracoscopy be experienced in inserting and managing a chest tube. In our opinion, this procedure should be incorporated very early in the training program of any pulmonary fellow who wants to learn thoracoscopy.

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Systemic Capillary Leak Syndrome

To the Editor:

Systemic capillary leak syndrome (SCLS) is a very rare idiopathic disease characterized by hypotension, hemoconcentration, 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 pathophysiologic 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, Clq 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 6½ years, 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.
Attempts to prevent the occurrences with theophylline, ephedrine, antihistamines, plateletpheresis, and plasmapheresis were unsuccessful. Only prednisone, 20 mg daily, seemed to abate the disease process.

Seven years later, a computed tomographic scan of the head revealed a pituitary mass, suggestive of an adenoma. Within a month of its detection, before it could be resected, the final and fatal episode occurred. Although requested, no autopsy was granted.

This patient had signs, symptoms, and laboratory findings, including paraproteinemia, consistent with SCLS. Of several previously described prophylactic therapies, only prednisone apparently altered the frequency or severity of the episodes.1-3 Interestingly, 7 years after the first episode, a pituitary mass was identified. The role of this pituitary mass in the SCLS can only be speculated upon. Adenomas have been found at autopsy in two previously described patients. The patient described by Clarkson et al had a chromophobe adenoma, while the patient described by Atkinson et al had a microscopic, non-beta islet cell adenoma. These findings suggest that an evaluation for neuroendocrine tumors must be a part of the diagnostic evaluation of patients with "idiopathic" SCLS.

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Nasal Ventilation Is Not the Final Word
To the Editor:

In their report in the October 1992 issue of Chest, Goodenberger et al described two neuromuscular patients who required long-term ventilatory assistance in the home setting. In these patients, tracheostomy tubes were removed in favor of using 10 to 12 h of predominantly nocturnal intermittent positive-pressure ventilation (IPPV) via nasal access. The authors concluded that "nasal ventilation may substitute for tracheostomy positive pressure ventilation . . . [and] should be considered as an alternative mode for patients with established tracheostomies who require only intermittent ventilatory support."

The authors also noted that these cases represented "the first well-documented reports of tracheostomy removal with substitution of a less invasive method of positive pressure ventilation" and that other studies did not discuss long-term success. However, the authors cited only one article outside the pulmonary or medical specialty literature and are apparently unaware of the numerous studies in various institutions that documented tracheostomy removal and conversion to noninvasive methods of ventilatory support for patients who required not only "intermittent ventilatory support" but up to 24-h ventilatory support.

In 1979 Alexander et al reported tracheostomy closure and conversion to daytime mouth IPPV and nocturnal rocking bed use for a patient with Duchenne muscular dystrophy. This patient continued to use 24-h noninvasive support without complications for 16 years.2

Viroslav et al and Bach described 20 high-level traumatic quadriplegic patients whose tracheostomies were closed and who were converted to noninvasive methods of ventilatory support. Sixteen of the 20 patients required 24-h ventilatory support, 11 had no ventilator-free time, and 4 had no measurable vital capacity when the tracheostomy sites were allowed to close. Despite this, following conversion there were no significant complications due to the use of noninvasive aids over a period of 45 patient-years.

In another center, 23 high-level traumatic quadriplegic patients were converted from tracheostomy IPPV to noninvasive support.1 Seven of the 25 patients used it for a mean of 7.4±7.4 years (range, 1 to 22 years) with no significant ventilator-free time without significant complications.

In other literature, 21 neuromuscular patients were converted from 24-h tracheostomy IPPV to 24-h noninvasive ventilatory support including daytime support by the intermittent abdominal pressure ventilator for a mean of 13 years.1 In 1985 Splaingard et al reported tracheostomy site closure and conversion of neuromuscular patients from tracheostomy IPPV to noninvasive support regimens. Bach and Alba reported the conversion of 13 patients who had been tracheostomized 25 times to 8- to 24-h noninvasive aid, including nasal IPPV, for a mean of 21 months with tracheostomy site closure and no significant complications.

In another report by Bach and Alba,35 of 143 postpoliomyelitis ventilator-supported individuals had had tracheostomies placed for management of acute medical or surgical conditions, including several who were tracheostomized on multiple occasions. Eleven of the 35 patients retained the tracheostomy for continued ventilatory assistance. Five of these 11 patients died, all within 4 years of tracheostomy placement; 4 died of pulmonary disease associated with mucus plugging and/or substance abuse, and the fifth died of cor pulmonale. The other 24 patients had the tracheostomy sites closed and were converted to noninvasive ventilatory support. Only 1 of these 24 patients who have been ventilator supported for 25.5±13.7 years is deceased. Her death was associated with substance abuse.

Thus, it might be argued that the recommendation of converting patients who require "intermittent" or predominantly nocturnal ventilatory support should be taken one step further. Studies that are now nearing completion demonstrate clear patient preference for noninvasive ventilatory support methods over tracheostomy and fewer complications for patients using 24-h noninvasive ventilatory support than for those using tracheostomy IPPV.

In addition, the emphasis by Goodenberger et al on conversion of patients from tracheostomy IPPV to nasal IPPV and their effort to distinguish their work from other studies in which "possible interim use of other noninvasive support" was used gives the inappropriate impression that this is somehow desirable. Indeed, it is clear from the references cited in their letter that for patients with little or no vital capacity or ventilator-free time, intermittent use of body ventilators is useful for allowing the tracheostomy site to close before using the noninvasive IPPV methods, which would hamper this.

Furthermore, since both of their patients—particularly their postpoliomyelitis patient—continue to have significant hypercapnia when unaided during daytime hours, these patients will not continue to do well on nocturnal nasal IPPV alone indefinitely. If reintubation and tracheostomy are to be avoided, daytime aid will have to be gradually extended. The preferred daytime methods are mouth IPPV for patients with or without ventilator-free time and the intermittent abdominal pressure ventilator for those with little or no scoliosis and no significant free time.7

Thus, for noninvasive aids to be successful over the long term for significant populations of ventilator-supported individuals, nasal, mouthpiece, and occasionally oral-nasal interface IPPV,11,18 the