Performing Thoracoscopy
The Controversy Continues

To the Editor:

The November 1993 issue of Chest continues to clarify the problematic thorascopic debate on who—surgically or medically oriented physicians—should perform the procedure.1 Hugo Esteva, M.D., from Buenos Aires, Argentina, argues that only surgeons should perform thoracoscopy, because he applies the dictum, “Do not get involved in procedures the complications of which you cannot solve by yourself.”

If we follow that logic to its extreme, then what surgeon will ever be able to operate when it is realized that some of their efforts will end up in renal failure requiring hemodialysis, respiratory failure requiring pulmonologists, cardiac disasters that require cardiologists, diagnostic dilemmas that require interventional radiologists, etc. If every surgeon was expected to follow-up his patient to the bitter end alone, then I doubt we would have the highly developed teamwork that constitutes the modern hospital.

Perhaps Dr. Esteva should heed the wise advice of an old Spanish proverb, “Do not muddy the water, for you may have to drink it soon.”

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REFERENCE
1 Esteva H. Who should perform thorascopy? The controversy continues [letter]. Chest 1993; 104:1637

Mechanical Ventilation for Pneumocystis carinii Pneumonia in Patients With the Acquired Immunodeficiency Syndrome

To the Editor:

The article by Staikowsky et al.1 published in the September, 1993, issue of Chest, is an important contribution to the field of ICU care for AIDS patients with Pneumocystis carinii pneumonia (PCP) and acute respiratory failure (ARF). However, we must take exception with the rhetorical question the authors pose in the title and the implicit answer they offer in their conclusion when they state that the prognosis of these patients remains poor. We point to the number of centers cited by the authors where improved survival has been shown in the past 5 years. Along with this, it should be noted that even the authors’ own survival figure of 18 percent, although lower than in any of the aforementioned centers, is still higher than that of any study published before 1987. Experts who once advanced the notion of the futility of mechanical ventilation (MV) in these patients have reversed their opinion.

Regarding the current published survival figures for AIDS, PCP, and ARF, the real question as we see it, is what accounts for the variation ranging from 18 percent to roughly 50 percent. Aside from the possibility of random statistical variation, there are at least two possible explanations. The first is that significant differences exist between published cohorts. An important problem is that current methods of measuring severity of illness in AIDS patients, including physiologic scoring systems, are limited in their ability to permit comparisons of patients in different centers. For example, in a series of this size (usually 25 to 100 patients) even the presence of a small number of patients with ultimately fatal comorbidities (other opportunistic infections, HIV related malignancies or neurologic diseases) carries the potential to alter markedly the survival figures.

A second plausible explanation for the variation in survival is that important differences exist in the treatment of these patients. Many therapeutic decisions are required in the care of AIDS patients with PCP and ARF including the timing of admission to the ICU, when to use bronchoscopy and positive pressure ventilation, preferences of steroid and antibiotic therapy (whether and when to use bacterial and fungal coverage as well as coverage for PCP), and finally the management of MV. The possibility that some centers have developed more successful patterns of treatment cannot be discounted.

The factors that determine which patients with AIDS, PCP, and ARF survive and why, are still poorly understood. Greater numbers of interested intensivists and more communication between medical centers are needed to understand variations in case-mix and treatment regimens. What is clear is that dismissing the improved survival statistics of many centers, as the authors have done, does a disservice to the complexity of the issue particularly when some will seize on this as a reason to deny ICU admission and/or MV to these patients.

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REFERENCES
3 Wachter RM, Luce JM, Hopewell PC. Critical care of patients with AIDS. JAMA 1992; 267:541-47