immediately if the country were to adopt a similar reasoned stance. Very austere yet defensible and practical preoperative testing guidelines were recently presented by Roizen. In his model, preoperative PTs and PTTs were sanctioned only for those patients with leukemia, hepatic disease, history or physical evidence of a bleeding disorder, or those taking anticoagulant drugs. Clearly, we have a long way to go to be in compliance with Roizen’s model, but the article in this issue by Kozak and Brath and these economic and political times justify bold moves, especially moves which are sound, correct, and evidence based. Just do it!

Craig S. Kitchens, M.D.
Gainesville, Florida

Chief, Medical Service, Veterans Affairs Medical Center.
Reprint requests: Dr. Kitchens, Medical Service-111, V.A. Medical Center, Gainesville, FL 32608

REFERENCES

11. Ewe K. Bleeding after liver biopsy does not correlate with indices of peripheral coagulation. Dig Dis Sci 1981; 26:358-93

The War Against Cigarette Smoking

The Final Battles

There seems to be a rhythm peculiar to war. Battles are fought but few appear decisive at the time, and little seems to change. However, as war reaches its conclusion, events occur at such a pace that one is barely able to keep up. And so it is with the war against cigarette smoking. Almost daily, there are announcements of proposed governmental action designed to curb smoking and to regulate the tobacco industry. David Kessler, Commissioner of the FDA, has proposed that cigarettes should be regulated as a drug, arguing that cigarettes are delivery devices for nicotine. President Clinton has prohibited smoking in the White House. The Bureau of Labor has sought to eliminate smoking from the workplace, while Representative Henry Waxman has introduced legislation that would prohibit smoking in all public buildings. For the first time in our nation’s history, there appears to be a confluence of support from the medical community, the legislature, and the executive branch to reduce or eliminate smoking from the national scene. Perhaps the long war against cigarette smoking is nearing its end.

The health consequences of cigarette smoking have been widely known for at least three decades. In 1964, the Surgeon General reported to the nation that cigarette smoking was causally related to cancer of the lung and larynx. Smoking has since been linked to cardiovascular disease, stroke, obstructive airway disease, pregnancy complications, and to a variety of neoplasms. The tobacco industry has sought to counter these reports by first denying the health effects of smoking, and then more recently, by invoking the notion of individual rights, i.e., the right of a person to assume risks. The latter argument has been severely challenged by data linking environmental tobacco smoke (ETS) to health effects in...
nonsmokers. Although the tobacco lobby argues that ETS is at most an annoyance acceptable to most reasonable Americans, there is growing evidence that exposure to ETS represents a genuine health hazard. Children exposed to the smoke of family members suffer an increased number of respiratory tract infections, an increased incidence of asthma, and for those with asthma, a worsening of their condition. Adults exposed to the smoke of spouses experience not only cough and eye irritation, but more importantly are at an increased risk for lung cancer. The effects of ETS on adult asthmatics are not as well documented as those in children. Experimental exposure to ETS may induce an acute irritant response in some, whereas in others, there is a gradual deterioration in flow rates with one or more hours of exposure, suggestive of an inflammatory effect on the airways. In this issue of Chest (see page 746), Jindal and colleagues demonstrate for the first time, a clinically significant effect of ETS in adult asthmatics. They show convincingly that exposure to the cigarette smoke of family members results in an increased number of acute episodes, increased steroid use, and increased emergency room visits. Thus, for those with asthma, exposure to ETS is more than an annoyance: it is clearly dangerous.

The evolving governmental viewpoint is that any risk from ETS is unacceptable. However, only a minority of Americans presently share this view. Ultimately, the national consensus regarding the acceptability of ETS will determine the strength of ultimate governmental action. For this reason, studies such as those reported by Jindal et al are important. As Americans become convinced of the dangers of ETS, they will become less accepting of the lethal habits of their fellow citizens. Only then will they accept, and ultimately demand, the strongest of governmental action.

Author S. Banner, MD
Manchester, New Hampshire

Chief, Pulmonary Division,
Veterans Affairs Medical Center.

REFERENCES

4 Tager IB. Health effects of "passive smoking" in children. Chest 1989; 96:1161-64

One- or Two-Segment BAL

More is Better

Bronchoalveolar lavage (BAL) in the diagnostic evaluation of pulmonary infections in the immunocompromised host (ICH) is now routinely performed and widely accepted. Experience and familiarity with the technique over the past decade have resulted in its wider application in the increasing numbers and subsets of ICH, leading to improvement in the diagnostic yield. In some infections, such as Pneumocystis carinii in HIV-infected patients, BAL is now the preferred procedure with which other diagnostic modalities are compared. Careful analysis of BAL results in P carinii infection in various subsets of ICH has provided information about the differences in organism load and diagnostic yield, effect of therapy or prophylaxis on yield, host inflammatory response, and localization of the organisms in different lung zones.

The standardization of BAL in the ICH, however, is a difficult task. The most important factor to be considered is the variable infection rate and intensity of infection in the different subsets of ICH. Technical factors include sampling error resulting from the selection of site, volume of fluid instilled and recovered, presence of airway obstruction, and adequacy of segmental wedging of bronchoscope. The effect of these variables in the diagnostic yield of various pulmonary infections in the ICH is largely unknown. An additional problem unique to the BAL diagnosis of certain infections, such as bacterial, opportunistic fungal, atypical mycobacterial, and cytomegalovirus (CMV) pneumonia, is the issue of contamination from airways as opposed to true infection.

Grebski and colleagues address the problem of site selection and report their findings for one-segment or two-segment BAL in the diagnosis of pulmonary infections in a mixed group of ICH. For P carinii pneumonia, most of the HIV-infected patients had two-segmental recovery of the organism, whereas two of five ICH without HIV infection had only one-segmental recovery of the organism. Meduri and colleagues found P carinii in only one segment in four of five patients without HIV infection undergoing two-segmental bilateral BAL. Levine and others reported only one-segmental (upper lobe) recovery of P carinii in 4 of 34 patients undergoing two-segmental (upper and middle or lower lobe)