factors that could be considered include permanent postoperative oxygen dependence, other quality of life issues such as severe ambulatory or activity intolerance, “excess” resource consumption while hospitalized, permanent loss of independence, and severe, permanent cardiovascular morbidity, eg, myocardial infarction with persisting congestive heart failure or disabling stroke. Input to determine these significant factors should not only come from physicians but from patients as only they can formally quantify which outcomes are and are not worth the risk of surgery. Once we know what we’re really worried about postoperatively, then we’ll finally be able to focus in on a large cohort and figure out strong predictors of these negative outcomes. Until that time, all we have are weak predictors of surrogate outcomes that may not have any clinical validity.

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REFERENCES

To the Editor:

We appreciated Dr. Cykert’s comments; however, we believe that one of the major points about our study has been misinterpreted. We are certainly not saying that patients having some of these complications should be denied surgical therapy based on the factors that we have found to contribute to a high risk of morbidity. The definition of what constitutes “significant” morbidity is agreeably inconsistent in the literature. Certainly, some of these complications are acceptable if the trade-off is a chance for cure from lung cancer. However, that should not mean that we can ignore these complications. Morbidity is very closely related to mortality in many cases. Patients can go on to die from what may seem a “nonsignificant” complication, which then cascades toward death. Furthermore, they do contribute to patient suffering, added use of resources, and certainly to an increase in health-care costs. We must continue to search for ways not only to identify patients who are at an increased risk for developing these complications but, more importantly, for methods to prevent their occurrence.

Predictors are presently weak, although we did find extended surgical resections, poor nutritional status, and prior chemotherapy to be significant.

Also, in our study no significant correlation between preoperative pulmonary function tests or arterial blood gases and the postoperative outcome was found.

We believe that these negative findings are due to the progress in preoperative evaluations made in the past two decades.

In our institution, it had been our routine to screen the candidates for lung resection with the pulmonary function studies with special attention directed to the FEV1, MVV, Dco, and ABG. When FEV1 is at a critical level (1.5 to 2 L), the postoperative FEV1 was estimated using the differential lung perfusion scan.

Since publication, we began to institute cardiopulmonary exercise testing to our borderline candidates in an attempt to improve our postoperative results.

Dr. Cykert states that quality of life issues, such as postoperative oxygen dependence, ambulatory or activity intolerance, and permanent loss of independence, are perhaps better measures of significant outcomes, rather than postoperative morbidity. It is true that these should also be important factors in decision making but, again, some of these long-term outcomes are influenced by postoperative morbidities. In addition, even these outcomes may be acceptable to patients if it means they can be alive and tumor free.

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Gender and Underlying Diseases Affect the Frequency of the Concurrence of Adult Polymyositis/Dermatomyositis and Interstitial Pneumonia

To the Editor:

The frequency of the concurrence of polymyositis/dermatomyositis (PM/DM) and interstitial pneumonia (IP) has been variously reported.1-3 We evaluated the prevalence of IP in 53 adult Japanese PM/DM patients at Tenri Hospital (1982 to 1987) and Kanazawa Medical University Hospital (1976 to 1993) according to gender (20 men, 29 to 76 years and 33 women, 21 to 86 years) and underlying diseases; idiopathic PM/DM (group 1, 35 subjects), PM/DM with a malignant neoplasm (group 2, 9 subjects), and PM/DM with other collagen vascular diseases (group 3, 9 subjects). These 53 adult PM/DM subjects who had definite PM/DM were diagnosed using Bohan’s diagnostic criteria.4 In this study, we estimated IP clinicopathologically at the time when PM/DM was diagnosed to exclude infectious lesions and drug induced pneumonitis.

Radiologically, diffuse interstitial pneumonia was observed in 22 subjects (41.5%), and biopsy specimens (transbronchial lung biopsy in 20 and open lung biopsy in 2) of these 22 cases revealed pathologic interstitial pneumonia. Clinical symptoms, signs, and pulmonary function tests also supported the radiologic and pathologic findings. Distribution of 53 PM/DM patients by gender, subgroups, and presence or absence of IP was shown in Table 1. In the total PM/DM subjects, the frequency of IP (54.5%) in women was higher than that (20%) in men (p<0.02), and especially in group 1 the frequency of IP (70%) in women was markedly higher than that (20%) in men (p<0.01). The frequency (48.6%) of IP in group 1 was similar to that (44.4%) in group 3, but the frequency (11.1%) of IP in group 2 was low. The frequency of IP in PM/DM subjects without malignancy (group 1 and 3) was higher than that in group 2 subjects with malignancy (p<0.05).

In the present study, the frequency of IP in Japanese PM/DM

<table>
<thead>
<tr>
<th>Subgroups</th>
<th>Men, IP (%)</th>
<th>Women, IP (%)</th>
<th>Both Sexes, IP (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PM/DM</td>
<td>+ 3 (20)</td>
<td>14 (70)</td>
<td>17 (88)</td>
</tr>
<tr>
<td></td>
<td>- 1 (40)</td>
<td>0 (0)</td>
<td>1 (1.1)</td>
</tr>
<tr>
<td></td>
<td>+ 12 (66)</td>
<td>4 (22)</td>
<td>16 (7.7)</td>
</tr>
<tr>
<td></td>
<td>- 2 (11)</td>
<td>5 (27)</td>
<td>7 (3.3)</td>
</tr>
<tr>
<td>Total</td>
<td>4 (23)</td>
<td>18 (78)</td>
<td>22 (41.5)</td>
</tr>
</tbody>
</table>

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