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.

How Should We Eject the Stents?

To the Editor:

In their article published in the August, 1994, issue of Chest, Noppen et al. describe the stent insertion technique first used in our department 2 years ago. Although their description is very accurate, one aspect, in our opinion, deserves to be pointed out more clearly. We have found it always useful to make a little mark on the instrument used for pushing the stent distally through the bronchoscope. The mark is made before inserting the bronchoscopic tubus and is so positioned as to be on a level with the proximal end of the tubus at the moment when the distal end of the stent fits the distal end of the bronchoscope. As soon as the instrument with the stent is inserted up to the mark, it is essential to keep it motionless while retracting the bronchoscope slowly. If the distal end of the tubus is positioned close to the distal end of the stentis, a very precise placing of the stent is usually possible with no need for further adjustment; this makes the method gentler for the patient.

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REFERENCES

To the Editor:

I thank Dr. Salajka for sharing with us his experience with the stent insertion technique, which we described in Chest (Chest 1994; 106:520-23), and which he already used in his department.

Dr. Salajka’s suggestions concern the “crucial moment” in our insertion procedure, that is the movement of the stent through the bronchoscope shaft, and the expulsion of the stent at the right time and at the right place. Dr. Salajka describes a visual reference mark, which he makes—if I understand him correctly—at the inner surface of the bronchoscope shaft, corresponding with the proximal end of the stent when its distal end reaches the distal tip of the bronchoscope. The stent is then fixed with the instrument (forceps), and the bronchoscope is retracted slowly, leaving the stent in place.

This technique seems to offer the advantage of a visual control of stent position inside the bronchoscope. It does not, however, give additional information on the stent position relative to the stenosis, since in both techniques the most important fact is the firm fixation of the bronchoscope relative to the stenosis in the stent insertion. Furthermore, Dr. Sajdak’s technique necessitates the simultaneous insertion of the forceps and a telescope, which seems to complicate and prolong the procedure (most bronchoscopists have only two hands), which is important because the patient cannot be ventilated during the insertion procedure.

In our experience, the beginning of the expulsion of the stent out of the bronchoscope can—after some practice—be felt by the bronchoscopist: the resistance against the stent movement gets less when the distal position of the stent reaches the proximal “elliptoid” opening of the bronchoscope shaft. Nevertheless, the use of a reference mark seems a good idea, but I would—as a compromise—make it on the proximal part of the forceps, corresponding with the correct distal position of the stent inside the bronchoscope, so that a simple eye-check is sufficient. We’ll try it next time.

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Obstructive Sleep Apnea
Oral-Nasal CPAP or Lipsesal CPAP

To the Editor:

I read with interest Prosise and Berry’s study of patients with obstructive sleep apnea using oral-nasal interfaces rather than nasal CPAP masks because of having too much nasal congestion for successful use of the latter. I wish to propose that the authors consider using a lipsesal (Paritan-Bennett, Boulder, Colo) as an alternative to nasal or oral-nasal interfaces. In 1993, we reported three patients with severe obesity hypoventilation and 160 others who received intermittent positive pressure ventilation (IPPV) via mouthpieces and lipsesals rather than use other noninvasive methods or tracheostomy IPPV for ventilatory support. Some individuals, whether using pressure-triggered or volume-triggered ventilators, successfully received nocturnal lipsal IPPV at pressures approaching 40 cm H2O. Nasal leakage during lipsal IPPV was readily compensated by the pressure-triggered ventilators, by increasing volumes with the volume-triggered ventilators, or when necessary, by using nasal cotton pledges. Less strap pressure is required to maintain a lipsal than an oral-nasal interface in position because of the smaller surface area that one needs to seal and because of the anchoring effect of the mouthpiece itself. In our experience, there are also fewer difficulties with pressure leakages due to breaking of the seal during sleep, and custom-molded acrylic lipsesals are more readily fabricated than are similar oral-nasal appliances. Although speaking clearly is less convenient during lipsal use, this is not a major problem for patients with intact upper extremity function who can easily displace the lipsal for this purpose. Patients also report less feelings