pressures in excess of 35 cm H2O are often required to maintain adequate alveolar ventilation. If such a principle is adopted, trainees must be educated as to the volume-pressure relationships of the respiratory system in health and disease.

Is it unreasonable to expect a trainee in surgery or medicine to grasp these concepts? In my experience at Bridgeport Hospital, a large community teaching hospital, and at Yale New Haven Hospital, I have found that trainees very rapidly master these principles. In fact, they are relieved to be disburdened of the 10 mL/kg rule; many find it counterintuitive that tidal volumes for different diseases should be the same! Once an appropriate tidal volume is chosen, the respiratory rate should then be adjusted to provide a minute volume that maintains eucapnia. In reality, such adjustments in tidal volume should be made daily in patients on volume-cycled ventilation. As the mechanical properties of the respiratory system improve or disintegrate during the course of illness, it is appropriate to reassert and readjust tidal volumes accordingly.

How does this approach differ from pressure-cycled ventilation? Most pressure-cycled ventilators stop flow at a set peak airway pressure, which also reflects resistive pressure. Insofar as the static airway pressure appears to be the most important reflection of alveolar pressures and pressure-cycled ventilators remain most commonly used, choosing tidal volumes based on static mechanics is a reasonable alternative to the 10 mL/kg rule. Mechanical ventilators are powerful machines, which, if used improperly, can cause complications, or worse, death. Management based on pathophysiology, as the new “plateau rule” would provide, is much less likely to do harm in the form of barotrauma or atelectasis and is more likely to aid trainees in understanding the supportive management of patients with cardiopulmonary diseases.

Constantine A. Manthous, MD, Bridgeport Hospital, Yale University School of Medicine, Bridgeport, Connecticut

Reprint requests: Dr. Manthous, Tower 8, Bridgeport Hospital, 267 Grant St., Bridgeport, CT 06610

REFERENCES

3 Tuxen DV, Lane S. The effects of ventilatory pattern on hyperinflation, airway pressures and circulation in mechanical ventilation of patients with severe airflow obstruction. Am Rev Respir Dis 1987; 136:872-79

Who Should Perform Thoracoscopic? The Controversy Continues

To the Editor:

Criticizing a letter of mine that pointed out as an example the financial problems that complications of thoracoscopic surgery performed by physicians other than thoracic surgeons could cause, Keith L. Ironside, Jr., MD, “follows that logic to its extreme” — not always an advisable method for subtle matters like medicine — arriving to the obvious conclusion that general complications cannot be treated by isolated doctors. As a surgeon, I was merely talking about technical complications.

But the sharp point is Dr. Ironside’s appeal to my Spanish sensitivity about proverbs. As far as I can remember, the University taught me that contamination is usually a microscopic issue, even in front of muddy water. As time goes by and mud settles down, it is becoming clear that while diagnostic thoracoscopic can be performed by other trained physicians — mainly pneumonologists—surgical thoracoscopic remains in the field of thoracic surgery.

There is, as usual, a gray zone that can still lead to some discussion. Loyal to my blood, when I find myself close to such obscure borders, I prefer to keep in mind the popular Spanish sentence: “Zapatero a tus zapatos” or “Shoemaker, to your shoes.”

Hugo Esteva, MD, FCCP, Hospital de Clínicas, Buenos Aires, Argentina

Errata

In the article “Reduction of Environmental Tobacco Smoke Exposure Among Asthmatic Children: A Controlled Trial,” by Hovell et al. published in the August issue of Chest 1994; 106:440-46, the Results Section of the abstract (page 440) and the body of the article (page 444, column 2) should read: “At the final 12-month visit, the experimental/counseling group sustained a 51% decrease in children’s exposure to cigarettes in the home from all smokers, while the monitoring control group showed an 18% decrease and the usual treatment control group a 15% decrease from pre-intervention.” The Results Section of the body of the article (page 444, column 1) should also read: “When exposure to all sources of cigarette smoke in the home was used as the dependent variable in a repeated measures ANOVA, the group (F[2,58]=13.86, p<0.01), time (F[4,232]=9.36, p<0.01), and group-by-time (F[8,232]=3.46, p<0.01) effects were significant. Children’s exposure to ETS in the home decreased for all three groups in varying degrees.” The values in Table 3 for exposure to all cigarettes at home (No. of cigs/day) at 12 months should be 2.5 (5.6) for group 1, then 5.6 (5.3) for group 2, and 6.6 (3.5) for group 3.

The following sponsors were inadvertently omitted from the March 1995 Supplement entitled the Thomas L. Petty 57th Aspen Lung Conference: Asthma—Structure and Function (Chest 1995; 107 [suppl 3]:S58-1698); 3M Pharmaceuticals; Abbott Laboratories; Allen & Hanburys (Div of Glaxo Inc); Amgen Inc; Amoco Chemical Co; Amoco Oil Co; Astra USA; Boehringer Ingelheim Pharmaceuticals, Inc; Burroughs Wellcome Co; Caremark Inc; Ciba-Geigy Corp; Corteic, Inc; Corvas International; Cybermedic/Jaeger; Dey Laboratories, Inc; Dura Pharmaceuticals; Fisons Pharmaceuticals; Forest Pharmaceuticals, Inc; Genentech, Inc; Glaxo Inc; Key Pharmaceuticals; Marion Merrell Dow, Inc; McNeil Pharmaceutical; Merck Research Laboratories & Merck Frost Canada, Inc; Miles Inc; Miril Medical Corp; Muro Pharmaceutical, Inc; Ohmeda; Pfizer Labs (Pfizer Inc); The Purdue Frederick Co; Puritan-Bennett Corp; Rorer Pharmaceutical Corp; RW Johnson Pharmaceutical Research Institute; Schering Laboratories; SmithKline Beecham Pharmaceuticals; Teijin Limited; The Upjohn Co; Zeneca Pharmaceuticals Group; The Francis Families Foundation; and The Aspen Lung Conference Endowment Fund.