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.

Adopting a Collective Noun for “Pulmonologists”

To the Editor:

I have enjoyed the communications of Dr. Sharma (CHEST 1994; 106:1932) and Dr. Hutcheon (CHEST 1995; 107:1773). I would suggest that the phrase “wheeze of pulmonologists” is poetic but carries an aftertaste of ill health with it and that the modifier “inspiration” has a lovely dual meaning but has a slight ring of technicality or possibly pretense. In these days of primary care politics, we should perhaps consider something a little simpler. Perhaps “a breath of pulmonologists” would be simpler while maintaining a sense of life and health and a soupçon of the meaning of “breadth.”

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The “Continuing” Education of a Physician

To the Editor:

Your recent editorial on physician education addressed the important issue of individual professional development (CHEST 1994; 106:1313). You emphasized the importance of those few crammed years at the start, while still at medical school. Until recently I would probably have agreed with that emphasis. However, for the 1994 Fall semester, I have taken time out of my cardiology practice to take the first-year medical school biochemistry course at the University of South Florida, in essence retaking a course I first studied 30 years ago in New Zealand.

It is true that things have changed. All the lecturers have PhDs, (not only MDs!), there is more structural chemistry, and clinical illustrations are frequently included. Teaching methods, including great handouts, have improved. Developments in molecular biology are illustrating that apparently common diseases and processes are remarkably complex. For example, dozens of subtle genetic modifications contribute to susceptibility toward diabetes, and the platelet is revealed as a wonderfully elaborate cell worthy of a lifetime of study. These advances provide powerful new therapies.

Why then do we “mature” physicians risk losing our clinical science focus by spending so much time on the three Rs—reimbursement, risk management, and referral. Some might blame overwork, social expectations, and lack of opportunity. Whatever it is, I do think that there are ways to foster your goal to “help people who were ill by virtue of becoming expert at medical science.” These might include: (1) introducing continuing medical education (CME) to students while still in medical school; (2) involving outstanding medical school faculty in physician CME programs; (3) making available challenging opportunities for physicians to recycle through medical school or postgraduate courses; (4) exciting boring, outdated, and repetitious material from CME programs; and (5) having journals, such as CHEST, include high-quality reviews of exciting changes in medical science and list stimulating CME opportunities.

I know that current medical students want this for themselves and expect it of us.

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REFERENCES


Talc Pleurodesis for Treating Malignant Pleural Effusions

To the Editor:

I read with interest the comprehensive review by Drs. Kennedy and Sahn (CHEST 1994; 106:1215-22) on “Talc Pleurodesis for the Treatment of Pneumothorax and Pleural Effusion,” which was published in the October 1994 issue of CHEST. I was glad to see that the discontinuation of parenteral tetracycline has prompted the renewed interest in talc pleurodesis in the United States. However, I have some comments to add as we have published several articles on management of malignant effusions in the last 5 years (two of them directly related with talc pleurodesis and indexed in the English medical literature as such1,2). We understand that our last article—which was published in CHEST only 2 months before the article by Kennedy and Sahn was submitted—could not be cited, but we were surprised that our former series published in 1989 was missing in their Table 2. In that article we reported our results with thoracoscopic talc poudrage in 60 patients with malignant pleural effusion, and our success rate was similar to that reported in the article by Kennedy and Sahn. We studied the relation between pleural fluid pH and outcome of talc pleurodesis, and we found that our results were also similar to those obtained by Sahn and Good5 with tetracyclines, concerning the poor outcome of pleurodesis in patients with low glucose and pH.

The dose used by us in talc poudrage for malignant effusion ranges from 5 to 8 g, although the density of talc is about 0.6 and weighing the exact amount of talc needed for each procedure is rather cumbersome. I would suggest to speak only in terms of vol-