Finally, I agree with Dr. Yim that the cost-effectiveness of fiberoptic pleuroscopy remains to be determined. What does seem clear, however, is its comparatively benign nature, which is appropriate to the clinical situation of these unfortunate patients.

Kevin Gleeson, MD, FCCP,
Pulmonary/Critical Care Medicine,
Hershey, Pennsylvania

Application of Thoracoscopy for Lung Metastasis

To the Editor:

In the January 1995 issue (CHEST 1995; 107:266-68), Dr. Liu and colleagues presented a series of patients with lung metastasis who were favorably managed via thoracoscopy. The authors conclude that the thoracoscopic management of lung metastasis is "safe and promising."

As a practicing thoracic surgeon, I have been reluctant to perform resections of solitary pulmonary nodules that I suspect to be malignant via the thoracoscopic technique. Colleagues as well as myself have anticipated the possible result of seeding the chest wall with tumor tissue when the specimen is extracted via this technique. This could be predicted on the basis of the principles of tumor biology. More recently, the possibility of chest wall recurrence should have been predictable based on the literature, which exists for laparoscopic management of intra-abdominal malignancies.

Thus, I was not surprised at the warning issued in an editorial by Allen and Pairolero.1 This editorial, which also appeared in January 1995, was prompted by two clinical series that showed chest wall recurrence of primary lung carcinoma, which was managed by thoracoscopy.

Therefore, it is quite predictable that within a few years, investigators will begin publishing articles on where the chest wall was seeded during the extraction of a pulmonary metastasis. I believe that Dr. Liu's conclusion is both premature and inaccurate.

Thomas R. McLean, MD, FCCP,
Shawnee Mission, Kansas

REFERENCE

To the Editor:

We appreciate the comments by Dr. Thomas R. McLean who emphasizes on the potential for seeding the chest wall with tumor tissue when the specimen is extracted after thoracoscopic resection. As mentioned in the literature,1,2 thoracoscopy provides a safe, direct, and conclusive resolution to the problem of the solitary indeterminate nodule. It has been established as a sensitive, specific, and therapeutic procedure for management of solitary pulmonary nodule.

The treatment of metastatic tumors to the lung in general has been wedge resection, as long as the margins are clear, this is considered therapeutic resection. Surgeons who performed thoracoscopic wedge resection on patients with suspected malignancy or metastasis should not allow the specimen to contact the chest wall incisions to prevent possible spread of tumor tissue.3,4 An endoscopic specimen sac should always therefore be used during retrieval of the specimen to reduce the likelihood of contact with the chest wall. Furthermore, larger specimens should also be placed in a plastic bag or surgical glove and removed by enlarging one of the trocar incisions to comfortably accommodate the lesion. These maneuvers allowed for the specimen to be removed intact and ensured that spillage of tumor or seeding of the trocar site did not occur. We thank again Dr. McLean for his comments, and we appreciate the opportunity to respond.

Hui-Ping Liu, MD, FCCP,
Thoracic and Cardiovascular Surgery,
Chang Gung Memorial Hospital,
Taipei, Taiwan, ROC

REFERENCES

What Is the True Impact of Crack on the Lung?

To the Editor:

In the January 1995 issue (CHEST 1995; 107:233-40), Haim and colleagues contributed a useful, comprehensive review of published data concerning the clinical, physiologic, and histopathologic effects of crack cocaine on the lung. They correctly noted the disparate results of the six studies that examined the effect of crack cocaine use on the single-breath diffusing capacity for carbon monoxide (Dco),1,2 which was found to be decreased in three of the studies1,2,6 but apparently unaffected in the others.3,5 The implication of the findings of a reduced Dco is the possibility of crack-related damage to the alveolar-capillary membrane or the pulmonary vasculature. In attempting to account for the discrepant findings, however, Haim et al erroneously stated that none of the cited studies took hemoglobin into account in the calculation of Dco. To the contrary, both of the studies from our laboratory3,6 adjusted the measured Dco for both hemoglobin and carboxyhemoglobin. Other possible causes of the discrepancy in the reported results for Dco in crack users include differences in (1) sample size, (2) frequency, intensity or duration of cocaine smoking or both, (3) confounding effects of other concomitantly smoked substances,2 (4) complications of intravenous drug abuse,3 or (5) other undefined characteristics of the samples of crack smokers who were investigated.2

Further well-designed, appropriately controlled studies are required to determine the true impact of crack smoking on gas transfer in the lung, as well as its mechanism, clinical significance, and reversibility with cessation of drug use.

Donald P. Tashkin, MD, FCCP,
UCLA School of Medicine,
Los Angeles

REFERENCES