Preflight Evaluation
Patients and Methods

To the Editor:

Dr. Dillard and his colleagues have characterized in their article (CHEST 1995; 107:352-57) that a hypoxic inhalation test at sea level and hypobaric chamber exposure are compatible predictors for altitude hypoxemia. The two groups of COPD patients were different in their spirometric status (FEV\textsubscript{1} for group 1 is 41±14\% and that of group 3 being 31±10\%); moreover, the presence of normocapnoea (PaCO\textsubscript{2}=38.0±4.7 mm Hg) in group 3 with FEV\textsubscript{1} ≤1 L (0.97±0.32) appears physiologically difficult to appreciate when a rise in PaCO\textsubscript{2} is likely.\textsuperscript{1} The authors have not mentioned how long group 3 patients were given hypobaric chamber exposure and have not qualified the reason for different periods of hypoxic inhalation/hypobaric exposure in subjects from groups 1 and 2 (15 and 30 min respectively). Furthermore, it is unclear that at what point of time the arterial blood gas analysis was done to see altitude hypoxemia. An exposure of 15/30 min may be quite short to see the hypoxic effect to long air travel since this duration is an important determinant of hypoxemia.\textsuperscript{2} A subclassification of chronic obstructive airway disease patients into predominant bronchitis vs emphysema would have been better to understand the utility of such tests in these different classes of patients who, pathophysio logically, are distinct from each other.

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Volume Reduction Surgery
How Selective Should We Be?

To the Editor:

As clinicians establish inclusion and exclusion criteria for patients with COPD considering volume reduction surgery, many are relying on the material by Cooper and Trulock\textsuperscript{1} and The Washington University School of Medicine guidelines\textsuperscript{2} as a benchmark. Centers are tending to select only patients with reasonable pulmonary function (FEV\textsubscript{1} >20\% pred)\textsuperscript{3} and exclude patients who retain carbon dioxide (PaCO\textsubscript{2} >55\%).

We have evaluated patients with extremely poor pulmonary function and who retain carbon dioxide and have proceeded to surgery in our program. We have been extremely gratified with the results of our most recent patient.

We evaluated a 67-year-old woman who was oxygen dependent, requiring 4 L/min at rest, sleep, and with activity. Her PaCO\textsubscript{2} was 67 mm Hg and she had an FEV\textsubscript{1} of 450 mL (17\% pred) preoperatively. Following transstrernal bilateral volume reduction surgery using pericardial strips, the patient recovered without incident. She was immediately postoperatively extubated. A small air leak resolved by postoperative day 5. Chest tubes were removed on postoperative day 7. She was discharged home, ambulatory, on postop-

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