the data should be analyzed in a given load. As shown in Table 1, the differences in standardized dyspnea scores (Borg scale/walking distance) between the ipratropium data and the baseline data were greater than those in the assessment with the Borg scale alone. The standardized dyspnea score in the ipratropium group was still greater than the standardized data in the albuterol; however, the effect of ipratropium on the dyspnea during exercise was more clearly observed. This is in agreement with the other observations. Because the patients with COPD often stopped the exercise testing mainly due to dyspnea, it would be reasonable to speculate that the reduced perception of dyspnea during exercise might contribute to improve exercise performance, resulting in the increased walking distance of the patients. Inversely, the maximal score of the Borg scale following the use of β-agonist or an anticholinergic agent may be closer to the baseline value, reflecting the increased demand of oxygen uptake and/or ventilation.

This may be a favorable effect of the bronchodilators for COPD patients, because the completely abrogated sensation of dyspnea may be harmful in terms of depriving the warning sign.

Because one of the major goals of bronchodilator therapy in COPD may be to relieve dyspnea as stated by the authors, an appropriate assessment of dyspnea during exercise may provide a valuable piece of information for both physicians and patients.

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REFERENCES


Improved Technique for Fiberoptic Pleuroscopy

To the Editor:

The role of fiberoptic pleuroscopy in the management of pleural disease is controversial. We have reserved this approach for patients who cannot tolerate general anesthesia. However, one major technical limitation of this approach is the poor maneuverability of the flexible fiberoptic 'bronchoscope' inside the chest.

We have devised a technique that we have found useful in directing the flexible scope inside the chest. We shorten a 28-F chest drain to about 25 cm by removing the end of the drain (which narrows the lumen). The truncated drain is then inserted into the chest using standard technique. The flexible bronchoscope is then slowly advanced through the drain under endoscopic vision until just the tip of the scope exits through. The flexible scope and the chest drain can then be maneuvered together as a unit and be directed to the location of the disease.

Although semirigid fiberoptic thoracosopes with rigid shafts and flexible tips are commercially available, they are big (10-mm external diameter) and not suitable to be used on patients under local anesthesia and IV sedation. Besides, they do not carry any instrument channels and necessitate the use of video assistance. We have used our described technique on several patients with very satisfactory results.

Anthony Ping Chuen Yim, BM, BCH, FCCP, Department of Surgery, Prince of Wales Hospital, The Chinese University of Hong Kong, Shatin, NT, Hong Kong

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Chestnuts

To the Editor:

In the ongoing discussion to find the appropriate expression for a multitude of pulmonologists, I submit a suggestion that was born of my residence in Ohio for many years and of my long association with my colleagues. I suggest the term, a "buckeye tree" of pulmonologists! I feel that this is clearly an obvious choice, justified by the alternate name for "buckeye," which is "chestnut." What could be more obvious!

Gerald L. Baum, MD, FCCP, Israel Lung Association, Tel Aviv, Israel

More On Talc Sterilization

To the Editor:

In the original article on talc sterilization published in the April 1995 issue (CHEST 1995; 107:1032-34), we indicated that cultures were planned for talc left on the shelf 1 year after sterilization by