unclear how the data of the control group were used. The authors state, “there were no changes in the control group.” This suggests that data of the control group were not compared with the data of the study groups, but data of different time points were compared within the group. It is therefore of interest that the number of five patients is too low, and with nonparametric data it is hard to demonstrate any statistically significant change.

Additionally, it is known that the vasodilator properties of dopexamine can induce a fall in BP, which can be corrected by the addition of extra fluids. However, the authors do not describe the fluid requirements of the patients during the study group, although in our opinion, these data are of interest.

Finally, we assume the given doses were in micrograms not milligrams as stated, and that not all data in the tables were “after dopexamine.”

Mark T. Patten, MB, ChB, and Armand R.J. Girbes, MD, PhD, Surgical Intensive Care Unit, University Hospital Groningen, Netherlands

REFERENCES

Patient Selection for Uvulopalatopharyngoplasty

To the Editor:

We read with interest the extensive review article on snoring by Victor Hoffstein (CHEST 1996; 109:201-22) but would like to clarify a few aspects from the surgical viewpoint.

Dr. Hoffstein states that when patients are assessed using sleep nasendoscopy, soft palatal vibrations are always associated with circumferential narrowing of the velopharyngeal lumen in nonapneic snorers and apneic patients who always collapse the same segment. The article by Croft and Pringle clearly states that the narrowing of the velopharynx is only present in a proportion of nonapneic snorers and that in a large group of both nonapneic and apneic snorers there is multisegment collapse, which may or may not involve the soft palate. We believe this finding makes a uvulopalatopharyngoplasty (UPPP) an illogical procedure to perform in this latter group of patients.

There is now evidence to justify sleep nasendoscopy as an essential investigation prior to listing snorers for palatal surgery. Camilleri et al. have shown that when patients with only palatal snoring (confined by sleep nasendoscopy) are compared with unselected snorers, success following UPPR rises from 61% cured (plus 27% better) to 94% cured (plus 6% better) in the endoscopic group. Although it is possible that patients with lesser degrees of tongue-base collapse may still benefit from palatal surgery, because of the lack of evidence to support surgery in this group, our clinical practice is to restrict UPPR to nasendoscopically confirmed single-level palatal snorers.

A. Simon Carney, MB, ChB, and Nick S. Jones, MB, BS, Department of Otolaryngology-Head & Neck Surgery, Queen’s Medical Centre, Nottingham, United Kingdom

REFERENCES

To the Editor:

Drs. Carney and Jones make two points. First, they object to my use of the word *always*, rather than *sometimes*, in stating that in nonapneic snorers the soft palate always vibrates in conjunction with circumferential narrowing of the pharynx (“always” refers to “vibrates,” not to “in conjunction”). Second, they draw attention to the fact that sleep nasendoscopy is a useful technique in identifying the site of collapse in nonapneic snorers, thus permitting better selection of patients for uvulopalatopharyngoplasty and thereby improving surgical success.

I have no major disagreements with these points, but I wish to point out the following information.

First, in describing palatal vibrations and circumferential collapse of the pharynx, I referred to the results of Croft and Pringle (Clin Otolaryngol 1991; 16:504-09) who found that “obvious palatal vibrations” were always present in snorers who had no observed episodes of airway collapse (group A patients). Since no results of polysomnography are given in that work, I could not assume that other patients (groups B and C), in whom palatal vibrations in conjunction with velopharyngeal collapse were not always present, were in fact nonapneic snorers.

Second, snoring represents a diffuse, rather than localized, abnormality of the airway. Vibrations of the airway walls, which produce the snoring sound, occur when the appropriate conditions linking airway wall compliance, cross-sectional area, and flow are satisfied. This may occur anywhere in the airway between the nasopharynx and laryngopharynx. Visualization of a single-isolated site of collapse within the airway, at a place easily accessible to a scalpel or laser, is no guarantee that the operation will be successful. However, systematic testing of this hypothesis for a well-defined group of nonapneic snorers, with proper objective and subjective assessment of snoring before and after surgery over extended follow-up time, is definitely worthwhile.

Victor Hoffstein, MD, St. Michael’s Hospital, Toronto, Ontario, Canada

REFERENCE

Video-Assisted Thoracoscopic Thymectomy vs “Maximal” Thymectomy for Myasthenia Gravis

To the Editor:

In an article entitled “Video-Assisted Thoracoscopic Thymectomy for Myasthenia Gravis,” Yim and colleagues (CHEST 1995; 106:1440-43) suggested that complete thymectomy can be achieved by this approach, although more investigations are needed to bet-