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 dem-
onstrate 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.1,2 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 mil-
ligrams as stated, and that not all data in the tables were “after
dopexamine.”

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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
erasendoscopy, soft palatal vibrations are always associated with
circumferential narrowing of the velopharyngeal lumen in nonap-
neic snorers and apneic patients who always collapse the same
segment. The article by Croft and Pringle3 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 uvulo-
palatopharyngoplasty (UPPP) an illogical procedure to perform in
this latter group of patients.4

There is now evidence to justify sleep nasendoscopy as an
essential investigation prior to listing snorers for palatal surgery.
Cammilleri et al5 have shown that when patients with only palatal
snoring (confirmed by sleep nasendoscopy) are compared with
unselected snorers, success following UPPP 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 clin-
ical practice is to restrict UPPP to nasendoscopically confirmed
single-level palatal snorers.

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1 Croft CB, Pringle M. Sleep nasendoscopy: a technique of
assessment in snoring and obstructive sleep apnea. Clin Oto-
aryngol 1991; 16:504-09
2 Carney AS, Robinson PJ. Assessment and management of snor-
3 Cammilleri AE, Ramamurthy L, Jones PH. Sleep nasendoscopy:
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109:1163-65

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 identify-
ing the site of collapse in nonapneic snorers, thus permitting bet-
ter selection of patients for uvulopalatopharyngoplasty and there-
fore 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
Otoraryngol 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
diagnostic investigations 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.1 This may occur anywhere in the airway between the na-
sopharynx and laryngopharynx. Visualization of a single-isolated site
of collapse within the airway, at a place easily accessible to a scal-
pel 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 fol-
low-up time, is definitely worthwhile.

Victor Hoffstein, MD,
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Toronto, Ontario, Canada

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1 Gaviely N, Jensen O. Theory and measurement of snore. J Appl
Physiol 1993; 74:2528-37

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

To the Editor:

In an article entitled “Video-Assisted Thoracoscopic Thymec-
tomy for Myasthenia Gravis,” Yim and colleagues (CHEST 1995;
105:440-43) suggested that complete thymectomy can be achieved
by this approach, although more investigations are needed to bet-

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