“in the absence of clinical symptoms or ECG evidence of complex arrhythmias, monitoring in a special care area, enzyme determinations, and cardiac imaging are not indicated.” From the review as presented, it appears that the authors have a limited familiarity with the current standard of care for cardiac injury in trauma patients and a limited ongoing participation in trauma care.

Krista L. Kaups, MD, FCCP,
Valley Medical Center,
UCSF Affiliated Hospitals,
Fresno, California

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Local Anesthesia With Thoracoscopic Talc Poudrage Pleurodesis

To the Editor:

The review of thoracoscopy by Harris and colleagues (September 1995) provides an excellent up-to-date overview of the subject. Obviously, there are many approaches to thoracoscopy, and we cannot expect unanimity of opinion in many controversial areas. However, it is important to take issue with the comment on page 574 that “thoracoscopic talc poudrage . . . usually requires general anesthesia” and again in Table 3 (talc pleurodesis) . . . is “effective but typically requires general anesthesia.” Although these comments are repeated often in the surgical literature, many of the references listed by the authors detail how the procedure is performed while the patient is under local anesthesia with or without conscious sedation, or sedation without intubation (their references 2, 27, 29-31, 58, and 59). In our last 173 thorascopies in California, most of which included talc poudrage, we have found local anesthesia with “as needed” adjunctive sedation to be satisfactory for both the patient and the thoracoscopist. Patients who are comfortable in the decubitus position in bed are generally comfortable during the procedure. More than a thousand patients who have had thoracoscopy in the Marseille teaching program received nonintubated sedation in a thoracoscopy suite. Recent emphasis on video-assisted thoracoscopic surgery (VATS) while the patient is under general anesthesia should not detract from the fact that medical thoracoscopy and talc poudrage do not require general anesthesia. Thoracoscopy may be more expensive than simple chest tube insertion and instillation of a sclerosant, if that sclerosant acts as quickly and effectively as talc poudrage. Controlled and uncontrolled observations suggest that talc poudrage may nevertheless be cheaper than the alternatives because of shorter hospital stays due to success with a single application and shorter periods of chest tube drainage. Better prospective, controlled cost-comparisons are necessary to confirm our own impression about cost. In the meantime, general anesthesia need not be factored into the cost equation.

Yossef Aelony, MD, FCCP,
Kaiser-Permanente,
Harbor City, California; and
Christian Boutin, MD, FCCP,
Hôpital de la Conception,
Marseille, France

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To the Editor:

The thoracoscopy experience of Drs. Boutin and Aelony using local anesthesia and talc pleurodesis is impressive, and we are grateful to them for raising an important question regarding the choice of anesthesia for thoracoscopy and talc poudrage pleurodesis. There is no doubt that this procedure can be carried out while the patient is under local anesthesia. It is our preference and the preference of some centers to perform this procedure while the patient is under general anesthesia. Regardless of the choice of anesthesia, all patients undergoing talc poudrage and pleurodesis require hospital admission and insertion of a chest tube. The majority of patients at our institution who require pleurodesis undergo bedside chest tube insertion and instillation of a sclerosing agent. There are no data to suggest that length of hospital stay after talc poudrage is affected by the choice of anesthesia. These patients typically have malignant pleural effusions and a short survival. In selected patients, thoracoscopy and talc poudrage are undertaken in the operating room while the patients are under general anesthesia. These patients tend to be younger with an expected survival exceeding 6 months. We do not use talc in young patients with benign diseases. It is important not to confuse bedside talc pleurodesis and thoracoscopic talc poudrage pleurodesis.

General anesthesia allows a more thorough examination of the pleural cavity. It facilitates complete visualization of the pleural space, lysis of pleural adhesions and loculations, and better distribution of talc in the pleural space. General anesthesia permits single-lung ventilation and application of gentle positive pressure ventilation to enhance lung reexpansion. Moreover, we believe that general anesthesia is more comfortable for the patient, especially when extensive adhesions exist in the pleural cavity.