allowing us to purchase a supply of plasma intermediates that we can then fractionate into Prolastin. Unfortunately, however, not all biological manufacturers process their plasma to intermediates in a manner consistent with our manufacturing process, so the supply of available intermediates will always be limited. Second, we have developed refinements in our manufacturing process that allow us to increase the amount of Prolastin made from a liter of plasma. Finally, we have added additional shifts at our Clayton, NC, and Berkeley, Calif, manufacturing sites to process the additional intermediates we were able to obtain. Through similar efforts, we have been able to increase availability of Prolastin to patients by almost 50% over the past 5 years. It is our plan to continue to strengthen these efforts in order to produce more of this important therapeutic agent and reduce the impact of the current shortage.

We must, however, realize that the limited amount of plasma and the extremely exacting standards required to manufacture Prolastin suggest that future imbalances between supply and demand may recur. Dr. Horowitz wonders about the efficacy of reduced dosages of Prolastin that may occur when a supplier faced with a product shortage attempts to extend supplies to satisfy patient needs. Unfortunately, data do not exist at this time regarding efficacy of reduced dosages.

In conclusion, Bayer recognizes the potential for future limitations in the supply of Prolastin and will continue to explore alternative means of obtaining additional plasma intermediates used in the manufacture of Prolastin, as well as process improvements and expansion of manufacturing facilities to increase product availability.

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Do Not Forget the Pathologist and the Cytologist

To the Editor:

I do not agree with any generalization of the results in Dr. Chechani’s paper1 on the increase in diagnostic success during fiberoptic bronchoscopy when combining different diagnostic procedures. The editorial comment by Dr. Kamholz2 emphasizes the enhanced diagnostic yield when using the transbronchial needle aspiration. Drs. Kamholz and Chechani did not consider the expertise of the pathologist and cytologist who did the “final and decisive” part of their jobs. Because the diagnostic success of any fiberoptic invasive procedure strongly depends on the skill of the pathologist and/or cytologist, this final step in making the right diagnosis must not be forgotten or underestimated. Studies such as the one published by Dr. Chechani cannot be extrapolated to the general diagnostic properties of the sampling procedures performed. The message of his study is only valid for Roswell, New Mexico. I have had the opportunity of working with different pathologists and cytologists, and thus, I had to learn how far the diagnostic yield of the different sampling methods depended on the skill of the individual pathologist and/or cytologist. Changing the cytologist has led to a tremendous increase in the percentage of lung lesions diagnosed correctly by brushing, without any change in the applied method. Choosing the right pathologist and cytologist for analyzing lung tissue is a major step in optimizing and enhancing the diagnostic yield of any invasive bronchoscopic procedure.

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REFERENCES

To the Editor:

I find the comments of Dr. Hans-Willi M. Breuer rather presumptuous. Dr. Breuer believes that bronchoscopic yield of brushing can be increased by changing the cytologist, and thus bronchoscopic procedures like transbronchial needle aspiration and transbronchial lung biopsies are unnecessary in patients with solitary pulmonary nodules and lung masses. This may be true in Görlitz, Germany, but definitely does not apply to the patients in my study.

Twenty-four patients were enrolled in Roswell, NM, and 25 patients were enrolled in Columbia, Mo. Roswell has two pathologists who have board certification in cytopathology. All specimens were thus evaluated by a competent cytopathologist. Besides, I personally reviewed all slides on these patients. If I had any doubts about a missed diagnosis on any of these cases, I would have asked for an outside opinion. The positive yields for different sampling techniques were similar to the two sites (Missouri and New Mexico). In our study, flexible bronchoscopy was diagnostic in 80% of the patients with primary lung cancer. This is one of the highest yields ever reported in patients with peripheral lung lesions and is a complement to the pathologists at University Hospital, Columbia, Mo, and Eastern New Mexico Medical Center, Roswell, NM.

Previous studies have already established that transbronchial biopsies and brushing are essential parts of a flexible bronchoscopy when evaluating a lung lesion in the absence of endobronchial abnormality. Our study shows that this diagnostic yield can be further increased by performing transbronchial needle aspiration.

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Selective Decontamination of the Digestive Tract

Consider Cross-infection of Staphylococcus aureus?

To the Editor:

Quinio et al1 studied selective decontamination of the digestive tract (SDD) in 148 trauma patients. The incidence of ventilator-associated pneumonia in the placebo group was 51% for a mean duration of mechanical ventilation of approximately 9 days. They