effective. Surely, this area needs further research; in the future, we hope to have more specific indications for medications in the treatment of sleep apnea.

The use of oral appliances is addressed in my review, but at this time there is insufficient data to know where to place this mode of therapy in the treatment algorithm. Since my review was submitted, the manuscript by Ferguson et al was published and shows promising results. As supportive evidence grows, this form of therapy may become one of our first line treatments.

Surely, CPAP is often prescribed initially for the treatment of OSA. However, studies documenting that patient compliance is often considerably less than ideal influence the placement of CPAP in my recommended algorithm. Surgery for sleep apnea is not successful enough to be a first line treatment at this time. New findings about pharyngeal surgery, discussed in the review, are worrisome. First, the pharynx size may revert to the original caliber several months after surgery. Second, late uvolopalato-pharyngoplasty failures are being reported. Third, pharyngeal surgery is often performed without preoperative identification of the site of obstruction.

In summary, I am aware that there are multiple approaches to treating the OSA patient. In spite of the treatment chosen, the response to a given treatment choice should be objectively measured, be it by monitoring CPAP machine timer, repeat polysomnogram following a few weeks of drug therapy, or documentation of improvement in apnea following surgery. When there is not an adequate response, the therapy should be changed based on this objective evidence. Our goal is to have the sleep apnea patient’s health improved with a form of treatment that is effective over time, and with which the patient is satisfied.

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REFERENCES

Descending Necrotizing Mediastinitis

To the Editor:

The report by Dr. Kruyt and colleagues (June 1996) of a case of descending necrotizing mediastinitis (DNM) causing pleuroesophageal fistula, treated without aggressive surgery, is interesting but should not be taken as general advice.

In the last few years, we treated 4 patients with DNM of dental origin, and only the fourth survived. We learned from experience to be as aggressive as the disease is, even if the patient seems to be in good condition. Dental resection, wide open drainage of the oral and cervical process, and thoracotomy are needed in cases of DNM.

A small, muscle-sparing thoracotomy can usually be carried out for a complete pleural “toilet” and early decortication, and also for a pleuropericardial window (two of our patients had purulent pericarditis). If needed, the contralateral side can be drained. Videothoracoscopy may also be an alternative.

Spontaneous perforation of the esophagus seems to be the probable cause of the DNM reported by Dr. Kruyt, in spite of the negative contrast swallow radiograph. Swallowed patent blue can show the tear during surgical neck exploration in dubious cases. A type T tube can then be inserted through the lesion as an esophageal drainage, avoiding its spontaneous enhancement and gaining a shorter postoperative period.

In the young patient with DNM, a small thoracotomy adds no significant functional risk but can be the best approach for the definitive surgical treatment of mediastinal, pleural, and pericardial collections.

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REFERENCES

To the Editor:

We thank Dr. Hugo Esteva for his remarks on our recent article about a case of descending necrotizing mediastinitis (DNM) causing a pleuroesophageal fistula. As indicated by the experience of Dr. Esteva, who describes 4 cases of DNM of whom 3 died, DNM can be a life-threatening infection. We therefore agree with Dr. Esteva that sometimes an aggressive treatment is necessary. If the cause of DNM is adequately treated and the patient is in good condition, a stepwise approach is justified, as described in our case report. Initially, DNM can be treated without aggressive surgical therapy. However, in the case of further deterioration of the patient, more extensive surgical drainage is indicated.

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Lung Volume Reduction Surgery

To the Editor:

In Toronto, Canada, we have had a major interest in the treatment of emphysema by lung volume reduction surgery (LVRS), particularly in the period 1965 to 1975. There were publications and presentations at that time. Some of our data have never been published, but these may be of help toward answering questions that are of present concern: how does one select the best patients for the operation; is the benefit of the operation long lasting; and what are the most useful tests for postoperative monitoring?

In selecting patients, worthwhile results were most likely when the vascular pattern was defined. Space occupation occurs when there is avascular change in the destroyed lung tissue, but it is also important to show that there is good vascularization in the remaining lung. Pulmonary angiograms and radioactive lung scanning were used at that time, but noninvasive high-resolution thin-slice CT scanning will now give equally good information.

We were able to get long-term follow-up in 10 patients who

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