Advance Directives, Revisited

To the Editor:

Tonelli is right: advance directives—no matter how detailed and complete—will not eliminate the uncertainty that surrounds end-of-life decision making (September 1996).1 Nor will the “development of professional standards of medical treatment.” Nor will “qualitative or ethnographic”2 research. However, if these instruments are used to encourage dialogue about the values, beliefs, and desires of our patients, they will have served their purpose.

Physician understanding of patient values and beliefs is and always will be imperfect. The most physicians can do is conscientiously strive to know their patients (and families) as well as possible in the context of caring relationships over time. When this is done, physicians put themselves in the best position to make right and good decisions for their patients.

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REFERENCES

Empyema Necessitatis due to Actinomyces odontolyticus

To the Editor:

We read with great interest the report by Bassiri et al (April 1996)1 about Actinomyces odontolyticus thoracopulmonary infections. We describe a patient who developed an empyema necessitatis due to A odontolyticus after pneumonectomy.

A 50-year-old man was referred to this hospital for fever (38°C), dyspnea, and pleuritic chest pain. He was a smoker and drank alcohol. Two years earlier, he had had a pulmonary tuberculosis infection, which was treated successfully. Later, pneumonectomy had been performed in another hospital because of hemoptysis for aspergillosis. Physical examination disclosed decreased breath sounds over the left lung and a soft, painful mass in the left lateral chest wall. The erythrocyte sedimentation rate was 48 mm/h. Testing for antibodies to HIV was negative. Chest radiograph revealed fibronodular scarring in the upper lobe of the right lung and opacification of the left hemithorax. Pleural fluid contained a purulent exudate. Gram's stain yielded Gram-positive cocci bacilli. Anaerobic culture showed a growth of A odontolyticus. Aerobic and Mycobacterium cultures were negative. Sulfur granules were not apparent in the samples. Closed thoracostomy tube drainage to suction was placed and an appropriate antimicrobial therapy was given. The patient responded to treatment.

Empyema necessitatis is a collection of inflammatory tissue that usually extends directly from the pleural cavity into the thoracic wall, forming a mass in the extrapleural soft tissues. It is a rare complication of a chronic pleural empyema. Mycobacterium tuberculosis is the most frequent cause.2 Pulmonary involvement with A odontolyticus is rare with only nine documented cases.1,3,4 To our knowledge, we describe the first case of empyema necessitatis caused by this microorganism. Bronchopleural fistula with empyema is the common complication after resection for complex aspergillosis, occurring often in patients after pneumonectomy.3 It is a possible mechanism in this patient. Clinicians should be aware that A odontolyticus can be associated with empyema necessitatis.

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REFERENCES
2 Gibbens DT, Argy N. Chest case of the day. Tuberculous empyema necessitatis. AJR 1991; 156:1295-96

Is the Symptomatic Improvement After Lung Volume Reduction Surgery Correlated With FEV1 in Patients With Diffuse Emphysema?

To the Editor:

In a recent issue of CHEST (July 1996), Roué et al5 demonstrated that lung volume reduction surgery (LVRS) results in symptomatic and spirometric improvement in patients with severe emphysema without large bullae. Further, they suggested that the symptomatic relief, ie, reduction of dyspnea, is correlated with improvement in FEV1 following LVRS. We basically agree with the authors that a reduction of dyspnea can be observed in patients with emphysema after LVRS probably due to improvement in pulmonary function including the increase in elastic recoil of the lung.2 However, the increase in FEV1 after LVRS may not play a predominant role in improvement of dyspnea in patients with emphysema.

Although the authors demonstrated a significant linear relationship between the decrease in dyspnea index, as indicated by Fletcher's scale, and the increase in FEV1 after LVRS, the significance of the relationship is not guaranteed. Since the Fletcher's category scale is not a linear scale, but a grading scale, linear regression analysis may not be applied for variables of Fletcher's scores. A more quantitative analysis of dyspnea using Borg scale or visual analog scale is necessary to assess the correlation between breathlessness and pulmonary functions.3

Although the analysis for the relationship between symptomatic response and spirometric variables is not appropriate in the current study, the possible relationship of lung functions to the