Thoracoscopic Talc Poudrage for Malignant Effusions

Should It Be the Procedure of Choice?

To the Editor:

I read with interest the combined experience from two centers in France reported by Viallat and colleagues (CHEST, December 1996) on thoracoscopic talc poudrage (TTP) to treat malignant pleural effusions using either local anesthesia with IV sedation or general anesthesia. The authors concluded that TTP was safe and effective, and recommended that it should be performed early on in patients with malignant effusions.

Talc has been shown by various studies, including ours, to be a highly effective sclerosant. We have recently completed a prospective, randomized study comparing TTP with talc “slurry” for symptomatic malignant effusions in patients who did not have trapped lungs. We could find no difference between the two groups with respect to chest drainage duration, postprocedural hospital stay, parenteral narcotic requirement, complications, or procedure failure (ie, recurrence). We therefore advocate that talc slurry should be considered the procedure of choice in view that it is simple and could be performed by the bedside. We emphasize that the treatment goal is palliation for a condition with very limited survival. Interestingly, a similar conclusion was reached in a porcine animal study.

A multicentric trial is underway in North America comparing these two modalities, and it would be interesting to see if the collective experience is in agreement with our own. Nonetheless, it is important to remember that as the techniques for many thoracoscopic procedures are becoming standardized, one would need to focus more on prospective, randomized studies to define the true role of these procedures in medicine.

REFERENCES


To the Editor:

We wish to thank Doctors Yim and Izzat for their interest in our experience on thoracoscopic talc poudrage (TTP) (CHEST, December 1996). They advocate that talc slurry should be the procedure of choice for pleural synphysis on the basis of their results in 29 patients, compared to 25 who underwent TTP. We have little personal experience with talc slurry, but the latter comes with more complications—including respiratory failures—and longer drainage times in most reported experiences.

I disagree with the authors’ statement that patients undergoing pleural synphysis have a very limited survival. We reported a median survival of 6.4 months in our paper, and a mean follow-up of 12 months (range, 2-120 months). Our main proposal is that talc pleurodesis should be performed early on in the history of malignant effusions, with the best available technique.

Even if talc slurry proves in the future to be as efficient and safe as TTP, it remains that in our experience thoracoscopy was diagnostic and therapeutic in 215 out of 360 patients (60%), and therapeutic only in 145. I thus quite agree with Yim et al, who “conclude that VAT not only provides an accurate diagnosis but also allows therapeutic procedures to be performed for malignant effusions that are associated with an acceptable morbidity.” Isn’t it worth learning thoracoscopy?

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REFERENCES


Fenoterol, Asthma Deaths, and Asthma Severity

To the Editor:

Rea et al (December 1996) report the findings of a cohort of 655 patients aged 15 to 55 years at a single Auckland hospital who were followed for the occurrence of death from asthma or a severe life-threatening attack. These are the same data that were previously published by Garrett et al, except that Rea et al have considered all asthma drugs whereas Garrett et al focused on the findings for fenoterol and salbutamol. However, publishing virtually the same data twice does not increase the validity of the study design or of the interpretation of the findings.

Garrett et al and Rea et al found that inhaled fenoterol was associated with severe life-threatening asthma (rate ratio=2.1), but that this risk decreased to 1.5 when the analysis was controlled for the markers of asthma severity used in our previous