trachea and mainstem bronchi and looking for deviation or evidence of luminal obstruction. Adenopathy, either peritracheal or hilar, is also assessed.

B—Bones and breast shadows: Inspect the bones for radiographic density, fractures, lytic lesions, or bony deformity. Evaluate the breast shadows for gross asymmetry, evidence of prior surgery, and any gross calcification.

C—Cardiac silhouette: Assess the cardiac silhouette for general size and contour.

D—Diaphragm: Assess the diaphragm(s) with attention to the contour and costophrenic angle, bilaterally.

E—Everything else: Review everything else around the lung fields including the subcutaneous soft tissues and pleural boundaries.

F—Fields: Finally, review the lung fields themselves looking for evidence of infiltrate, mass, and pattern of vascularity.

It is my experience that new learners using this approach are able to recognize both the presence of chest radiographic abnormality and absence of normality. Further, as their experience grows, they are readily able to add interpretation of these abnormalities with clear differential diagnoses and place them in the appropriate clinical context.

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Chronic Ventilator Unit Admission Criteria

To the Editor:

I greatly enjoyed reading the article entitled, “A Community-Based Regional Ventilator Weaning Unit: Development and Outcomes,” by Bagley and Cooney in the April issue of CHEST.1 Their stress of rehabilitation of ventilator-dependent patients in their unit is an important aspect in successful weaning of these patients. I thought that it was an excellent article.

I do have one comment about a statement made on page 1027 of the “Discussion” section in this article. The authors stated, “To be accepted by the Mayo Clinic unit, the Health Care Financing Administration (HCFA) required that the attending physician attest in writing that the patient was likely to wean or return to home on a regimen of mechanical ventilation.” I would like to point out that these criteria applied to all four of the HCFA weaning unit demonstration sites. I believe that the reason for this requirement was that HCFA desired not to have these units filled with hopeless ventilator patients, which would cost them a great deal of money. Instead, they wished to have some assurance that the patient was either likely to be weaned or would have caregivers or other resources in the home, which would allow for mechanical ventilation within the home on discharge. This latter situation is extremely difficult to achieve in the elderly Medicare population.

I believe that the efficacy of these units was demonstrated by the HCFA demonstration project and that further steps need to be taken by HCFA to take advantage of this study. There is no reason for suitable patients to be discharged to waivered ventilator units outside of acute care hospitals if appropriate patients can be better served in the acute care hospital where they currently reside, dependent on mechanical ventilation. This study by Bagley and Cooney is another in a continuum of studies that demonstrates the efficacy of these ventilator-dependent units, whether they be in the acute care hospital or freestanding.

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REFERENCE

1 Bagley PH, Cooney E. A community-based regional ventilator weaning unit: development and outcomes. Chest 1997; 111:1024-29

To the Editor:

The Health Care Financing Administration (HCFA) ventilator weaning demonstration projects for which data are available,1,2 clearly show that a high percentage of carefully selected patients that have become ventilator dependent can be weaned using the principles of rehabilitation medicine. I believe the location of such a unit, inside or outside of an acute care hospital, is less important than the multidisciplinary rehabilitation approach. Weaning from mechanical ventilation is only one of the useful roles rehabilitation-based ventilator units may play in the medical community. Dr. Gracey’s comments illustrate the dilemma of selection criteria for a ventilator unit. In many communities, long-term care facilities for ventilator patients are rare, resulting in the custodial care of an estimated 11,500 ventilated patients in US acute care hospitals in 1990.3 If extramural ventilator units do not accept the “hopeless” patients to which Dr. Gracey refers, substantial losses accrue to acute care institutions. Further, many ventilator-dependent patients have potential to regain the ability to perform many of the activities of daily living, even though they remain fully or partially ventilator dependent. Because, as Dr. Gracey points out, it is extremely difficult to marshal sufficient resources to permit these patients to receive mechanical ventilation at home, the HCFA guidelines may have the effect of denying such patients beneficial treatment.

Capitation may remove some of the inefficient artificial regulatory barriers that direct patients into various sorts of post-acute care settings, allowing attention to be focused on where the best outcomes and most efficient care can be provided. Dr. Gracey certainly has been a leader in the area of specialized weaning units. I hope that his comments continue to focus attention on the role ventilator units can play in the integrated delivery systems now developing.

Also, please note that in the acknowledgments section of our article, the name of Dr. Michael Baron was inadvertently omitted.

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1 Criner GJ, Kreimer DT, Pidlooa L. Patient outcome following prolonged mechanical ventilation via tracheostomy [abstract]. Am Rev Respir Dis 1993; 147:A574
3 A study of chronic ventilator patients in the hospital: A patient profile and analysis conducted by the Gallup organization for the American Association of Respiratory Care. Dallas: AARC, 1991