assessed on a subset of the survivors. Nonetheless, the authors showed that most of the patients returned to a functional status similar to their baseline before the critical illness. This is important information for patients and their physicians because many patients would not choose ICU care if the outcome was survival with a markedly diminished functional status or quality of life. Future studies should incorporate reliable and valid measures of quality of life and functional status among the other outcomes of ICU care, especially for those patients with chronic or terminal diseases.

We need to learn a lesson from the changing survival after acute respiratory failure due to PCP: things change. Treatment for the underlying HIV infection has undergone dramatic changes in the past 2 years. There are now more than 10 antiretroviral drugs approved in the United States for the treatment of HIV infection, and the clinical improvements recently obtained with combination drug therapy are unprecedented. Persons with HIV infection are having dramatic responses, not just in virologic markers, but in improved functional status, quality of life, and survival. Despite the problems in providing access to these therapies, the Centers for Disease Control and Prevention recently reported a significant decline in the death rate from HIV infection in the United States for the first time since the AIDS epidemic started. These dramatic changes in treatment for HIV infection will almost certainly improve the long-term outcomes of ICU care and may affect the reasons for admission to the ICU, as well as the short-term outcomes. Only continued studies of ICU outcomes for patients with HIV infection will provide physicians and patients the information they need to make decisions about whether and when ICU care is in the best interest of patients.

J. Randall Curtis, MD, MPH* Seattle

Assistant Professor of Medicine, Division of Pulmonary and Critical Care Medicine, Department of Medicine, University of Washington.

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Reprint requests: J. Randall Curtis, MD, MPH, Harborview Medical Center, Box 359762, University of Washington, 325 Ninth Ave, Seattle, WA 98104; email: jrc@u.washington.edu

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Is Less Better?

The past few years have seen video-assisted thoracic surgery (VATS) gradually becoming the preferred approach for selected surgical procedures. The benefits of VATS over conventional surgery are abundant. Standard thoracotomy is one of the most painful incisions, and the chest is probably the most suitable body cavity for minimally invasive surgery. By virtue of the rigidity of the chest wall, once the lung is collapsed, there is ample room for maneuvering instruments.

VATS is still in evolution. The question is, does VATS, as we currently practice it, represent an end
point that only requires minor refinements or is it an intermediate step to an even less invasive approach? We believe that both views may be correct. VATS represents a spectrum with a purely endoscopic approach at one end and a video-assisted approach (with a utility minithoracotomy) at the other end. For the purely endoscopic procedures, there have been attempts to modify further the surgical access and mode of anesthesia. The former resulted in the development of 2-mm “needlescopic” instruments and the latter in therapeutic thoracoscopy under local anesthesia. It is entirely possible that in the future, thoracoscopic sympathectomy and splanchnicectomy could be performed under local anesthesia via an essentially percutaneous route with miniaturized instruments as an outpatient procedure.

In this issue of CHEST (see page 528), Noppen and colleagues report the use of thoracoscopic splanchnicolyis in patients with severe pancreatic or postoperative epigastric pain refractory to conservative management. The authors emphasized their own VATS technique of general anesthesia without selective one-lung ventilation, using electrocautery instead of surgical division of nerve fibers, and not using chest drains postoperatively. The relative merits of their technique could only be judged based on the long-term results and morbidity compared with a standard VATS approach (with selective one-lung ventilation and division of nerve fibers). These data, however, are not available. The authors’ attempt to achieve prolonged pain relief in three of eight patients is difficult to interpret because contralateral interventions were refused by those patients. However, one must be assured that this is not related to inadequate exposure due to the partially ventilated lung or to incomplete cauterization of the nerves. The other question that immediately lends itself to debate is whether these maneuvers made the procedure less invasive. Thoracoscopic splanchnicectomy was first reported by Worsey et al. This and subsequent reports showed that the morbidity is very low and recovery rapid after a standard VATS approach.

Attempts to further minimize the trauma of thoracic surgery should be encouraged. However, these new techniques must obey the principles of advances in surgery, that is, carry added benefits to patients without compromising the results that can be achieved by already available techniques. It is also important not to overlook the potential risks of intrathoracic operations, for one should not erroneously believe that minimally invasive operations will ever equate with minor surgery. The operator must be equipped to handle any intraoperative complications that may arise. These were some of the concerns raised when VATS was first introduced, and they will continue to exist even if the trauma of thoracic surgery can be further minimized. Carefully conducted clinical trials should precede the general acceptance of a new technique or technology, no matter how attractive it may appear initially.

Anthony P. C. Yim, MD, FCCP
Mohammad Bashar Izzat, MD
Hong Kong

Division of Cardiothoracic Surgery, Department of Surgery, Prince of Wales Hospital, Chinese University of Hong Kong

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