Communications to the Editor

Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Please include a cover letter with a complete list of authors (including full first and last names and highest degree), corresponding author’s address, phone number, fax number, and email address (if applicable). Specific permission to publish should be cited in the cover letter or appended as a postscript. CHEST reserves the right to edit letters for length and clarity.

Prophylaxis For Deep Venous Thrombosis

The ACCP Antithrombotic Statement, Revisited

To the Editor:

This limerick is based on recommendations in the Fourth ACCP Consensus Conference on Antithrombotic Therapy, which was published in the October 1995 supplement to CHEST. I hope it will offer some teaching points regarding prophylaxis.

Low-Risk Patients
If you’re young and your appendix is hot And you haven’t a risk for a clot To avoid being dead Just get up out of bed Need heparin? No, you do not.

Moderate-Risk Patients
If the surgery doesn’t go fast But you’ve no other risks from the past Your choices are three ES,\(^5\) IPC,\(^4\) Or heparin subQ in the a**.\(^5\)

Higher-Risk General Surgery Patients
If your risk is a little bit more Than the guy I just mentioned before Low molecular weight Or the Big Stuff,\(^7\) Q8 Is advice from page 324.\(^8\)

Higher-Risk General Surgery Patients Prone to Wound Complications
If you’re old with a big operation And you’re prone to a wound complication I suggest IPC It will be more risk-free Than heparin for anticoagulation.

Very High-Risk Patients With Multiple Risk Factors
If you’re old and they cut on your heart SubQ heparin would be a good start Add stroke, fat, and cancer\(^7\) Two things is the answer\(^10\) ‘Cause your risk will be off of the chart.

Total Knee Replacement
If they’ve found that you need a new knee\(^1\)
Standard heparin won’t keep you clot-free Low molecular weight Heparin is great The alternative is IPC.

Footnotes
1. Patients with age <40 years, undergoing minor surgery.
2. Patients with age >40 years, undergoing major surgery.
3. ES = elastic stockings.
4. IPC = intermittent pneumatic compression.
5. Actually, this shouldn’t be “in the a**,” but it rhymed.
6. Patients with age >40 years, undergoing major surgery who also have additional risk factors.
7. Unfractionated heparin.
9. Or any number of additional risk factors. See the reference in footnote 8.
10. Combination of heparin or low molecular weight heparin and IPC.
11. Risk of deep vein thrombosis is approximately 60% without adequate prophylaxis.

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Patient-Centered Ventilation

To the Editor:

All agree that mechanical ventilation can be a life-sustaining and life-saving medical intervention with clear application in a wide variety of illnesses that lead to the common end point of respiratory failure. However, there is considerable controversy about the specific approach to a ventilated patient. For example, a clinician’s preference in the choice of tidal volumes and respiratory rates is frequently based on expert opinion more than on clinical data from human trials or even on the clinician’s own experience. This strategy can occasionally lead to faulty medical decision making.

A frequent case in point is the patient who does not interact well with the ventilator despite an optimal ventilator approach (ie, small tidal volumes and high respiratory rates for a patient with ARDS or high tidal volumes and low respiratory rates for a patient with a COPD exacerbation). After an assessment to rule out acute changes in such a patient’s medical condition, a typical clinical response is to increase the level of sedation or even to initiate paralysis. It is my experience, however, that better matching of the ventilator settings to the patient is frequently all that is needed to settle a patient down. In practice, I will often allow the patient to breathe spontaneously with 5 to 10 cm of