hospital adds considerably to the total cost, it is important to determine if these wide differences relate to the relative rapidity of each technique or merely to differences in medical systems that place differing emphasis on early hospital discharge.

In their introduction and in the “Discussion” section, Zimmer and colleagues perpetuate the myth that thoracoscopic talc poudrage is more expensive, due to a requirement for general anesthesia and an operating room. However, ample contemporary literature exists detailing this procedure under local anesthesia, with many centers reporting the use of an endoscopy suite for the procedure.2-10

Although my bias favors thoracoscopic talc poudrage because of personal experience with short stays and high success rates; further information needs to be available before concluding that any of these 3 techniques is generically more cost-effective than the others under ideal circumstances. Indeed, cost-effectiveness at a given center may depend on the particular skills of the local medical-surgical team, such that any of the 3 techniques might be most cost-effective at a given location.

Yossef Aelony, MD, FCCP
Banco Palos Verdes, California

REFERENCES
6 Oldenberg FA Jr, Newhouse MT. Thoracoscopic: a safe, accurate diagnostic procedure using the rigid thorascoscope and local anesthesia. Chest 1979; 75:45-50
7 Mathur PN, Boutin C, Loddenkemper R. Medical thoracoscopcy: technique and indication in pulmonary medicine. J Bronchology 1994; 228-39

To the Editor:

Our paper comparing chemical pleurodesis with talc slurry and bleomycin had several goals. The first was to objectively assess the efficacy of bleomycin and talc in this simplified approach to unilocular malignant pleural effusions. Our data clearly indicate that with appropriate patient selection, both agents are effective. What is equally clear is that the significant difference in cost between the two agents (talc, $12.36 per unit dose vs bleomycin, $955.83 per unit dose) would favor the regular utilization of talc in these patients.

Dr. Aelony is clearly an advocate of thoracoscopic talc poudrage in the management of malignant pleural effusions. He points out this approach can be done under local anesthesia and also that no specific prospective randomized comparison of cost has been made between talc slurry pleurodesis and thoracoscopic talc poudrage. All of our chest tube insertions and talc slurry installations were done at the bedside. No additional personnel, equipment, procedure, or operating room time was required. Dr. Aelony points out that length of stay in our study showed

bleomycin patients staying 5 days and talc patients staying 8 days. We included this data for completeness, but in fact, virtually all of these patients were managed while on the medical service. Many of them were hospitalized for a multiplicity of reasons and the treatment of their malignant pleural effusions was only a component of their hospital stay. The entire treatment period, as pointed out in the letter, was only 48 h in each patient. Except for the one patient who required secondary treatment in the bleomycin group, no patient’s hospitalization was extended simply on the basis of procedural problems.

We continue to use thoracoscopic and talc poudrage in patients from whom we require diagnostic tissue or who have multiloculated pleural effusions. It is clear to us that thoracoscopic and poudrage is unnecessary in the majority of our patients. Talc slurry instillation following bedside tube thoracostomy is an extremely straightforward, safe, and cost-effective method of managing patients with unilocular malignant pleural effusions.

Donald E. Low, MD
Peter W. Zimmer, MD
Virginia Mason Medical Center
Seattle

Seizures and Pulmonary Embolism

To the Editor:

In the September 1997 issue of CHEST, Marine and Goldhaber1 described two patients with massive pulmonary embolism (PE) who presented with generalized seizures. The authors claimed that theirs was the first report of seizure activity as a presenting feature of PE. Actually, Hamilton and Thompson2 in 1963 reported on a patient (Case 7) with autopsy-proven massive PE in whom a generalized convulsion was the presenting manifestation. Several other investigators3-6 have also called attention to seizures, either generalized or localized, as early manifestations of PE.

Herbert L. Fred, MD, FCCP
University of Texas Health Science Center at Houston

REFERENCES
1 Marine JE, Goldhaber SZ. Pulmonary embolism presenting as seizures. Chest 1997; 112:410-42
4 Hussey H, Katz S. Pulmonary embolism. GP 1955; 12:59-68
6 Fred HL, Yang M. Sudden loss of consciousness, dyspnea, and hypoxemia in a previously healthy young man. Circulation 1965; 31:3017-19

Superior Vena Cava Obstruction in Cystic Fibrosis

To the Editor:

I reviewed with interest the article by Chow et al in the November 1997 issue of CHEST regarding superior vena cava