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 contem-
porary literature exists detailing this procedure under local anes-
thesia, with many centers reporting the use of an endoscopy suit
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
Banclo Palos Verdes, California

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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
instillations 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 bleo-
mycin 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 multilocu-
lated 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 thoracotomy 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 Gold-
haber1 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 mani-
festation. Several other investigators3-6 have also called attention
to seizures, either generalized or localized, as early manifestations
of PE.

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and hypoxemia in a previously healthy young man. Circula-
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Superior Vena Cava Obstruction in
Cystic Fibrosis

To the Editor:

I reviewed with interest the article by Chow et al1 in the
November 1997 issue of CHEST regarding superior vena cava

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