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.

New Treatments Out There?

To the Editor:

Drs. Robin and McCauley have provided us with an interesting and useful review of the platypnea-orthodeoxia syndrome in the December issue of CHEST. The syndrome often appears to be due to a right-to-left shunt through a foramen ovale, sometimes opened by pulmonary hypertension, but what is unclear is why the shunting is positional. Does the supine position cause preferential shunting from the inferior rather than superior vena cava with, presumably, a lower oxygen saturation or is the oxygen saturation in one of the cava altered by the supine position?

They have also reminded us of Dr. Robin’s important critique of the Swan-Ganz catheter, the role of which in the management of critically ill patients still remains to be established. They also remind us of Dr. Robin’s impressive experience with opiates in the management of severe dyspnea, a potentially important strategy in many patients with COPD and others. Why has there not been more experience with this treatment?

M. Henry Williams, Jr., MD, FCCP
Department of Medicine
Albert Einstein College of Medicine
Bronx, New York

REFERENCE

1 Robin ED, McCauley RF. An analysis of platypnea-orthodeoxia syndrome including a “new” therapeutic approach. Chest 1997; 112:1449-51

To the Editor:

We thank Dr. Williams for his gracious and generous letter. His letter implicitly suggests a mechanism for determining accurately the risk-benefit ratio of using opiates (or other therapies) for platypnea-orthodeoxia syndrome.

The syndrome is so rare that a classical randomized prospective controlled clinical trial will require many years to accumulate an adequate number of patients.

On the other hand, n=1 trials in which physicians with appropriate patients alternated placebo with opiate therapy in random fashion may quickly provide rigorous evaluation of, say, opiate therapy. Such trials can be integrated by a mechanism set up by CHEST.

In any case we are grateful to Dr. Williams.

Eugene D. Robin, MD
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Robert F. McCauley, MD
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REFERENCE


Editor’s Note

CHEST will be delighted to accumulate case reports with n=1 trials as described by Dr. Robin in his editorial and as encouraged by Dr. Williams in his correspondence. The mechanisms and treatment of platypnea and orthodeoxia are of great interest to the readers of the journal. Parenthetically, Dr. Robin called the Editor of CHEST and was quite flustered because he has so rarely received flattering letters, such as that sent by Dr. Williams.

REFERENCE

1 Robin ED, McCauley RF. An analysis of platypnea-orthodeoxia syndrome including a “new” therapeutic approach. Chest 1997; 112:1449-51

Scoring Evidence of Pulmonary Rehabilitation Effectiveness in COPD

To the Editor:

The conclusions of the American Association of Cardiovascular and Pulmonary Rehabilitation and the American College of Chest Physicians Consensus Panel were important additions to the credibility of evidence as to the effectiveness of pulmonary rehabilitation in COPD. The authors assigned a letter grade to designate the strength of the scientific evidence: “A—scientific evidence provided by well-designed, well-conducted, randomized, or non-randomized controlled trials with statistically significant results that consistently support the guidelines recommendations; B—scientific evidence provided by observational studies or by controlled trials with less consistent results to support the guidelines recommendations; C—expert opinion that supports the guidelines recommendations because the available scientific evidence did not present consistent results or because controlled trials were lacking.”

The results of this excellent review concur in large with our meta-analysis of randomized controlled trials of at least 4 weeks of respiratory rehabilitation, and our systematic review of ran-