5. Nonprogressive pneumomediastinum but subcutaneous emphysema.
6. No signs of sepsis.

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Mediastinoscopic Treatment of Mediastinal Cysts

To the Editor:

We read the article by Smythe and colleagues (August 1998) with interest. Many surgeons have advocated a minimally invasive approach to mediastinal cysts, but thoracoscopic approaches are currently more popular than mediastinoscopy. Although Smythe and coworkers have extensive experience with thorascoscopic surgery, they favor mediastinoscopy for mediastinal cysts. We share their enthusiasm for mediastinoscopic treatment of selected mediastinal cysts.

Mediastinal cysts in favorable locations can be almost completely excised, as reported by Smythe and coworkers and others. However, large cysts in the subcarinal region are intimately associated with vital structures; mediastinoscopic excision of these cysts can be hazardous. In such cases, we prefer to perform a mediastinoscopic cystotomy, and use intracavitary doxycycline for cyst sclerosis. We agree with Smythe; mediastinoscopic treatment of selected mediastinal cysts is safe and effective. Surgeons treating mediastinal cysts with mediastinoscopy should be familiar with several treatment techniques and their limitations.

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Nasal Mask Ventilation in Children

To the Editor:

The ACCP should be congratulated on its recent Consensus Report on "Mechanical Ventilation Beyond the Intensive Care Unit." This thorough report describes the current state-of-the-art technology for home ventilation. However, we take exception to the comments regarding nasal mask ventilation in children. The report states that infants and young children may not tolerate nasal masks, that nasal mask ventilation is not usually recommended for use outside the ICU, and that nasal mask ventilation in young children must be considered an investigational technique.

Although adaptation to nasal masks is generally more labor-intensive in children and may require behavioral therapy, children do tolerate nasal masks well. This was demonstrated by three recent articles describing the successful long-term use of nasal masks for home continuous positive airway pressure in a total of 248 infants and children, of whom were <6 years of age.

The literature documents the successful and safe use of home nasal mask ventilation in young children with neuromuscular disease, as well as children with congenital central hypoventilation syndrome. In addition, many studies have shown its efficacy in adolescents with neuromuscular disease or cystic fibrosis, as well as in pediatric patients with acute respiratory failure or in the hospital environment. Although there are relatively few published series of nasal mask ventilation in pediatrics, clinically it is being used widely in children throughout the United States and Europe. We have successfully used home nasal mask ventilation in a total of 76 pediatric patients with chronic hypoventilation at our institutions; the youngest was 3 months of age.

As summarized in the ACCP report, other techniques for noninvasive ventilation in children are fraught with technical problems (eg, negative pressure ventilators are cumbersome and may result in obstructive apnea), have limited efficacy (eg, rocking beds), or are appropriate for only a small segment of the population (diaphragm pacers). Tracheostomies have high rates of physical and social morbidity, and even death in young children. Certainly, young children with chronic respiratory failure should be managed by experienced centers. We strongly agree with the conference recommendations that more research is needed in this area. However, we think nasal mask ventilation shows great promise as an alternative to positive pressure ventilation via tracheostomy in children with chronic hypoventilation. To dismiss nasal mask ventilation as a purely investigational