confirmation even in a small cohort of patients. However, one must be careful in applying these data to clinical practice. This study was not a trial of therapy aimed at producing negative fluid balance, but rather an observational study demonstrating that its occurrence is associated with improved outcomes.

Sepsis remains a common and major clinical challenge for clinicians of all specialties. Therapy of sepsis must be aimed at correcting the underlying illness while supporting the physiology of the patients. The association of a particular physiologic state with better outcomes does not necessarily imply that therapy aimed at producing a similar physiologic state will be advantageous to the patient. Specifically, fluid management should continue with the aim of repleting the intravascular space, and a goal of inducing negative fluid balance is not warranted at this time.

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REFERENCES
7 Marik P, Varon J. The hemodynamic derangements in sepsis: resuscitate the gut and not the body? Chest 1998; 114:854-860

Thromboembolism Management in Europe vs North America

Are the Differences Clinically Significant?

The most ambitious and probably most widely cited set of medical guidelines in use among contemporary clinicians covers the expansive topics of management and prevention of thromboembolism. So far, five editions have been published in CHEST as a consensus statement by the American College of Chest Physicians (ACCP). Rapidly approaching their 2-decade anniversary, these guidelines are remarkable because of their extensive implementation throughout the medical community. Although the scope of the consensus statement initially focused on prevention of venous thromboembolism, it has now widened to include all aspects of arterial and venous thromboembolism management and prevention. As the subject matter broadened, the font of the text diminished, and the weight and page length of the CHEST supplement increased. Initially published at a 3-year interval, the rapid pace of developments in the field has led to a planned revision in 2 years from the most recent fifth edition (November 1998).

Whereas most consensus groups have worried about their guidelines falling on deaf ears, some members of the ACCP consensus group have discussed informally whether their statement has become too influential. It does serve de facto as an authoritative standard-of-care guideline for thromboembolism management and, as such, is used widely by medical malpractice plaintiff and defense attorneys.

A logical question is, “What is the secret of the group’s success?” Most of the credit goes to the co-chairpersons, James E. Dalen, MD, FCCP, and Jack Hirsh, MD, FCCP. They have insisted on careful and detailed organization of the process, with firm timelines, well-written and referenced draft statements from working groups (which become chapters in the final CHEST supplement), and, whenever possible, “bottom line” recommendations formulated on the basis of evidence from clinical trial results. To achieve consensus, the two dozen or so working groups present their summary statements at a 3-day meeting of specialists convened in Tucson.
Disagreements are discussed in a time-limited debate; moderators require the debaters to cite evidence and judge the strength and levels of the evidence; they cut short those who advocate by anecdote and oratory. After the meeting concludes, working-group chairpersons submit “final drafts” to Drs. Dalen and Hirsh, who personally edit them and thus produce the next edition of the consensus statement.

A specialist in thromboembolism wants to be invited to participate in this ACCP consensus statement process. Drs. Dalen and Hirsh have the unenviable job of deciding whom to invite. As the scope of their subject matter has increased, from prevention to management and from venous thromboembolism to all thromboembolism, they have needed to include more and more experts. They must ensure that the group, by its sheer magnitude, does not become too unwieldy to function quickly and efficiently.

The group has retained in its title the term North American. Mexico is not well represented, and North American is really referring to the United States and Canada. However, at this point, perhaps the term North American should be dropped and replaced by the term International. After all, the consensus statement is put together with international representation, including experts from Italy, The Netherlands, and France. Like the Internet, the consensus group has, in fact, become globalized.

In this millennium, where international communication is virtually instantaneous, one must wonder whether there are important differences in thromboembolism management between Europe and North America. I believe that the differences are minor and that there is often no consensus among experts representing the many countries of Europe. Even the definition of Europe keeps changing. Technically, the continent of Europe comprises >50 nations. But is the Europe of the accompanying “European response” by Verstraete et al, published in this issue of CHEST (see page 1755), representing only those countries that are members of the European Union plus Switzerland? In the accompanying European response, why is there no Russian representation? Have most countries in the former Soviet Republic been overlooked? Is Scandinavia underrepresented based on the many Scandinavian contributions to the field of thromboembolism? I contend that the authors of the European response faced the same problem of selecting experts that confronts Drs. Dalen and Hirsh. They needed to limit the number of coauthors and, therefore, could not include representation from every part of Europe.

Are there important differences between America and Europe? Of course there are. But these differences are political, economic, social, and cultural. They are not centered on the management of thromboembolism. For example, an important political difference that divides America and Europe is that most European countries favor the weakening of sanctions against Iraq. An important economic difference is that unemployment remains high in many of Europe; perhaps, as a result, the euro has fared less well against the dollar than predicted. An important social difference is that health care and health maintenance is considered a right in Europe, similar to police and fire protection. An important cultural difference is the continued widespread acceptance of cigarette smoking in many parts of Europe, even among health-care professionals.

In Europe, venous thromboembolism prophylaxis for total hip and knee replacement begins preoperatively with low-molecular-weight heparin, not postoperatively. This is a difference, but not one of major import. Most specialists agree that prevention of venous thromboembolism for patients undergoing elective hip or knee replacement does require intensive prophylaxis and that a prophylaxis program consisting solely of aspirin and early ambulation is inadequate. More low-molecular-weight heparins are available in Europe than in the United States. Most Europeans feel a ventilation lung scan yields little incremental value to a perfusion lung scan and a chest radiograph. This partial list of differences is minor in the overall scheme of things.

As we enter the new millennium, it is important that we foster increasing international cooperation and collaboration. The European response published in this issue of CHEST provides a useful reminder that contemporary medical standards and consensus statements are becoming globalized and are no longer limited to a single continent. I am certain that as the sixth edition of the consensus statement is being written, the European response will be viewed as a useful critique. Undoubtedly, some of the European experts who have felt disenfranchised in the past will be satisfied that their viewpoints and expertise are acknowledged and actively sought.

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**Reference**