Correction to the Scientific Record

To the Editor:

I am writing to you as first author of three articles,1–3 the most recent of which appeared in CHEST last year.1 After publication of that study, my research team and I became aware of a potential compromise in the quality of part of the data collected by the subject interviewer. Because of this, we initiated a formal review of this data set and of all previous data involving the interviewer. The data in question formed the basis of two other CHEST articles, the first a full-length article,2 and the second, an expanded abstract from the published proceedings of an Aspen Lung Conference.3 The formal data review process was carried out under the auspices of the University of California, San Francisco, following both internal University and external National Institutes of Health policies. The review committee was chaired by Dr. Dorothy Rice, Professor Emeritus, Institute of Health and Aging. I am writing now in conjunction with completion of that review and consistent with the review committee’s findings and recommendations, which were accepted on February 22, 2000, by the University of California, San Francisco.

The review confirmed that the interviewer had created some records that were duplicated or inconsistent in ways constituting clear misconduct in 75 of 1,710 interviews conducted in the studies involved; additional interviews contained fragmentary documentation, which could have compromised at least part of 449 cases. We have extensively reanalyzed the data sets in question, and have excluded compromised and potentially compromised records. The entire set of corrected data analyses, which found no substantial impact on the principal major findings and interpretation of the previously published papers, can be found on the World Wide Web at http://www.chestnet.org/publications/17566/.

Because of the misconduct in question, my coauthors and I believe strongly that the scientific record should be corrected.

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Morale and Depression in Patients Treated Surgically for Intractable Aspiration

To the Editor:

In a recent issue of CHEST (November 1999), Takano and coworkers1 demonstrated that surgical therapy to prevent aspiration improved the depression and mood of patients with intractable aspiration and their families.

In principle, to prevent aspiration pneumonia, the alimentary routes are changed to enteral routes, requiring nasogastric tube feeding and gastrostomy.2 However, as suggested by Takano et al.,1 the bypasses from stomach to nostrils by the tubes may contribute to the development of aspiration pneumonia.3,4 It has been reported that even a smaller size of nasogastric tube did not prevent or reduce microaspiration in patients receiving mechanical ventilation.3 Because silent aspiration and swallowing disorders are very important elements in the pathogenesis of aspiration pneumonia and/or nosocomial pneumonia in patients with stroke and pulmonary disease,5–9 the prevention of aspiration is very important for the management of repetitive lower respiratory tract infections in patients with dysphagia. Because medical therapies and swallowing rehabilitation cannot always control the incidence of recurrent aspiration pneumonia in patients with dysphagia, laryngectomy and laryngotracheal separation could be choices for the management of intractable aspiration.

Although the efficacy of the surgical therapies has been determined conventionally in terms of physical condition and the rate of aspiration pneumonia, the variables of health-related quality of life (HRQOL), including morale, depression, mood, and energy, have not been assessed comprehensively, in either patients with dysphagia or their families. The therapeutic strategies to prevent aspiration are usually determined by the families, since the patients are often suffering from stroke, brain damage,

References


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Editor’s Note: Please visit http://www.chestnet.org/publications/17566/ for reanalysis of the data set upon which these publications were based.