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). An electronic version of the communication should be included on a 3.5-inch diskette. 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.

Surveillance Bronchoscopy Following Insertion of Silicone Stents

To the Editor:

We read with interest the report in CHEST by Toshiro Matsuo and Henri Colt (November 2000). The article addresses whether routine scheduling of flexible fiberoptic bronchoscopy is warranted 2 to 3 months after silicone stent insertion for central airway obstruction. A surveillance fiberoptic flexible bronchoscopy (SFFB) was scheduled to be performed within 2 to 3 months after the date of initial stent insertion. The onset of new respiratory symptoms prompting flexible fiberoptic bronchoscopy prior to the scheduled fiberoptic bronchoscopy was classified as an emergent fiberoptic flexible bronchoscopy (EFFB). Seventy surviving patients underwent SFFB (n = 39) or EFFB (n = 31). Of these, 39 of 70 patients (55.7%) did have new symptoms and 42 of 70 patients (60%) had evidence of complication at endoscopy. This included detection of complications in nine asymptomatic patients.

The authors do not report data regarding the postoperative day when these patients developed symptoms related to the stent or when bronchoscopy was performed. It is evident, however, that a bronchoscopy procedure (either SFFB or EFFB) was useful in >50% of the patients at 2 to 3 months after stent placement or earlier.

To our knowledge, there is no way of identifying the group at high risk of developing these complications. The authors conclude that a general policy of routine scheduling of surveillance bronchoscopy after silicone stent insertion is probably unwarranted.

We believe a different conclusion should be considered. These data could be used to estimate the mean time when these patients developed symptoms related to the stent or when bronchoscopy was performed, and to recommend that instead of leaving SFFB until 2 to 3 months after stent insertion, it should be brought forward. This would be of particular aid to patients who are referred from outside facilities to have a bronchoscopy at the time when they are most likely to have a stent-related complication, rather than waiting for symptoms to develop.

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Reference
1 Matsuo T, Colt HG. Evidence against routine scheduling of surveillance bronchoscopy after stent insertion. Chest 2000; 118:1455–1459

How Much Incidence Is Enough?

To the Editor:

It is with great interest that I read the article by Matsuo and Colt in CHEST (November 2000) about routine surveillance bronchoscopy after stent placement. Some comments from the point of view of a practicing bronchologist seem warranted. Strict adherence to the study objective, namely assessing the rate of stent-related complications in asymptomatic receivers of the devices (n = 31), ends up in nine asymptomatic patients with stent-related complications (29%), four of whom required reintervention. In other words, 13% of all asymptomatic patients undergoing routine bronchoscopy needed endoscopic revision due to side effects of stents. There is no sense at all in minimizing this rate by relating it to the total number of stented patients. If surveillance bronchoscopy was supposed to serve as a preventive measure against respiratory emergencies, then this goal was not attained because only a minority of patients remained asymptomatic until the scheduled control date.

Eighteen individuals of the entire sample (n = 88) died before bronchoscopy control was thought of. No evidence is given that, had they survived, they would have remained asymptomatic until the time of scheduled surveillance bronchoscopy. Nor is it “unlikely that death [of at least some of them] resulted from a stent-related complication,” since the authors do not substantiate this assumption. Thirty-one patients underwent emergency bronchoscopies due to respiratory symptoms before the date of scheduled surveillance, and eight patients were symptomatic at the time of surveillance. Thus, on the whole, 57 patients did not reasonably belong to the group where surveillance was (or, in case of the deceased, would possibly have been) indicated or performed.

But, apart from the message that surveillance ended up in quite a few (13%) of patients requiring reintervention, the data tell us a different and not less interesting story about the natural history of stents: after stent placement, 39 of 70 alive patients (56%) had newly occurring respiratory symptoms that necessi...
Augmentation Therapy in \( \alpha_1 \)-Antitrypsin Deficiency

To the Editor:

Dr. Lieberman’s article (November 2000) provides important new information about the effect, or lack thereof, of \( \alpha_1 \)-antitrypsin in patients deficient in this important protein. Although as yet unproved, the use of augmentation therapy in this group of patients may reduce the rate of decline of lung function and pulmonary tissue loss, at least in some individuals. Dr. Lieberman’s data indicate that there may be other significant benefits to both the patient and community as a result of the reduction in morbidity (respiratory infection) with its consequent economic savings.

Dr. Lieberman’s data build on observations made by Cantin and Woods in 1994. The latter group retrospectively analyzed a group of \( \alpha_1 \)-antitrypsin-deficient patients who had received augmentation therapy. They observed that “the conditions of individuals in our program remained clinically and functionally stable with several subjects having fewer hospitalizations than before augmentation therapy was initiated.” Thus, there may be other benefits from augmentation therapy. Further study of augmentation therapy would seem sensible.

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Dr. Kahana’s Lesson

Some More To Learn

To the Editor:

In the September 2000 issue, CHEST published the last article by Dr. Kahana, a distinguished member of the American College of Chest Physicians, who described the natural history of lung cancer in a patient. The news was that the patient was the author himself. He tried to let us understand what happens on “the other side of the desk,” and I agree with the Editor’s decision to accept and publish the article.

When studying cancer patients, we report cases and numbers, not emotions and feelings. Dr. Kahana reports his double experience as doctor and patient at the same time through the diagnostic approach, the doubt on what was better to do or not to do, the underevaluation of some symptoms and signs, the prognostic expectancy, the therapeutic perspective, the rethinking of a known disease of other patients, and the realistic view of