success rate with simple aspiration. Andrivet and colleagues concluded that thoracic drainage “via a chest tube was significantly more effective in the treatment of pneumothorax” than simple aspiration.5

Our consensus panel was also aware of the unpublished British Thoracic Society (BTS) survey that Drs. Miller and Harvey mention in their letter. We did not believe, however, that this approach, noted in this survey, by British practitioners of the 1993 BTS pneumothorax guideline recommendations6 for simple aspiration could substitute for investigative data. Moreover, two recent publications report that the majority of UK physicians do not conform to the 1993 BTS guidelines in managing patients with spontaneous pneumothorax.7,8

We regret the description of the ACCP document as “biased.” The 32 members of the expert panel were selected through an explicit methodology described in the statement and represent the leading published experts in this field. Also, the entire Delphi consensus panel, the ACCP Health and Science Policy Committee, and the Executive Committee of the ACCP Board of Regents reviewed, revised, and approved the statement before its publication. The writing committee responded to the minority concerns of Drs. Miller and Harvey by referring to the BTS guidelines in the published statement and by stating that “two panel members argued that simple aspiration is usually effective for stable patients.” The consensus document could not do more to represent the opinions of a small minority of the expert panel without unjustifiably altering the majority consensus.

We recognize that extensive practice variation exists in the management of spontaneous pneumothorax. Indeed, reports of this practice variation prompted the design of the ACCP Delphi study.9 A critical analysis of the literature demonstrates that insufficient high-grade data exist to support the development of an evidence-based guideline on pneumothorax management. To its credit, the ACCP proposed that a statement necessarily based on expert consensus in the absence of high-grade outcome data should use an explicit consensus methodology and quantify the degree of consensus for each of its recommendations. We believe that the Delphi pneumothorax statement ably fulfilled this degree of consensus for each of its recommendations. We believe on expert consensus in the absence of high-grade outcome data insufficient high-grade data exist to support the development of approbation, noted in this survey, by British practitioners of the 1993 BTS pneumothorax guideline recommendations6 for simple aspiration could substitute for investigative data. Moreover, two recent publications report that the majority of UK physicians do not conform to the 1993 BTS guidelines in managing patients with spontaneous pneumothorax.7,8

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Low-Dose Spiral CT Screening

To the Editor:

I applaud Frederie W. Grannis, Jr., MD, for his views on the subject of lung cancer screening (February 2001).1 As a lung cancer survivor, I have followed the debate over low-dose spiral CT screening closely and with great interest. I have been dismayed by the backlash against the Early Lung Cancer Action Project (ELCAP) study (and the ongoing research by the International Collaboration to Screen for Lung Cancer [ICScreen]), led by the National Cancer Institute (NCI), and by several physicians in the lung cancer field. I have read the numerous admonitions against jumping on the low-dose CT screening bandwagon. These cautionary tales have often been delivered in condescending tones aimed at those of us who can’t possibly understand what good science entails, and why these studies are necessary. There is no doubt that a prospective, randomized, controlled trial would be the ideal study for evaluating low-dose spiral CT screening for lung cancer. There is no doubt that additional studies are needed to further characterize and quantify the risks involved in screening for lung cancer using low-dose spiral CT. What are the costs of waiting to pursue widespread screening research based on the ELCAP findings until a prospective trial such as the one proposed by the NCI can be completed?

In answering this question, Dr. Grannis provides a context for this debate that has heretofore been missing, or at best, gratuitously acknowledged—that the devastation wrought by lung cancer is relevant. The high incidence and absurdly low survival rate associated with lung cancer is relevant. The fact that progress in preventing and treating lung cancer has occurred at a glacial pace (over decades) is relevant.

We know what the world looks like without low-dose spiral CT screening. The human toll and economic burden of lung cancer is enormous and unrelenting. I ask those lung cancer specialists who caution against moving forward until a prospective, randomized, controlled study can be conducted: just what world are you living in that affords you such a luxury? From my view, the ongoing ELCAP/ICScreen research deserves our full support.

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To the Editor:

Spirometry is a simple and common procedure performed to access pulmonary lung function. Complications from testing are rare but can include dizziness from hyperventilation, and vaso-vagal reactions. The development of pneumomediastinum following spirometric testing has also been previously reported in two normal subjects and in one immunocompromised patient with presumed Pneumocystis carinii pneumonia.

Patients undergoing spirometry are instructed to take a deep inspiration to total lung capacity and then to expire vigorously. This causes a rapid increase in lung volume and pressure changes in the alveolus. These sudden changes in alveolar volume and transpulmonary pressure can lead to alveolar rupture and subsequent air entry into the bronchovascular sheath.

We report a 32-year-old white man who developed a pneumomediastinum after undergoing spirometry. The patient had a history of perennial allergic rhinosinusitis and had complained of vague and intermittent upper-chest tightness for several months. He denied any gastric reflux symptoms.

Spirometry was performed before and after administration of nebulized levalbuterol hydrochloride (0.63 mg) and findings were normal. Two hours later, he developed severe throat and neck pain. He also had a change in his voice to a high-pitched voice. Physical examination noted palpable crepitus in the neck. A high-resolution CT scan of the chest was obtained to exclude pneumomediastinum after undergoing spirometry. The patient had a quent air entry into the bronchovascular sheath.

Although spirometry is a safe and useful test, one should be aware of the physiologic changes that occur in the respiratory tract with the vigorous straining required to complete the test. Furthermore, one should suspect pneumomediastinum as a complication if the patient complains of severe neck or throat pain following the procedure.

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Dying With Respiratory Disease

To the Editor:

Since little is known about the symptoms and treatments for dying patients with respiratory diseases, we carried out a chart review for symptoms experienced in the last 2 days of life and the effectiveness of treatment. The medical records of 150 sequential patients who died at a respiratory division in an university hospital in April 1994 through December 2000 were reviewed. The 150 patients who died had an average age of 65 years, and 101 patients (67%) were men. One hundred nine patients had malignancy (lung cancer [n = 101], others [n = 5]), and 41 patients had benign disease (interstitial pneumonia [n = 19], COPD [n = 11], others [n = 11]). Dyspnea and cough were documented in 69% and 28% of patients with benign disease, respectively. Pain was present in 32% of patients with malignant disease. In patients with benign disease, 59% were receiving ventilatory support, 49% underwent resuscitation, and 63% died in ICUs. On the other hand, patients with malignant disease were less likely to be in ICUs (p = 0.0001, χ² test), to receive ventilatory support (p = 0.0001), or to receive resuscitation (p = 0.0001) compared to those with benign disease.

Our patients had dyspnea more frequently than patients in previous studies of hopelessly ill patients. This might be explained by the difference in study population. Patients with malignant disease in our series had pain less frequently, which may be due to pain control by appropriate medication. Not a small percentage of our patients with benign disease received life-sustaining treatments. Too often, such treatments are instituted in hospitals, especially in ICUs, without sufficient thought to the proper goals of treatment. Chest physicians are required to

Figure 1. High-resolution CT scan of the chest shows extensive emphysematous changes in the mediastinum. The air extends to encase the trachea, esophagus, arch vessels, and thyroid.