The classic teaching holds that emphysema causes loss of elastic recoil and thereby “functional” airways obstruction. Although emphysematous airspace destruction commonly occurs with airflow obstruction, the two are not interdependent processes. Results of the HRCT of the chest correlate well with histologic emphysema and have helped to identify patients with emphysema but not airflow obstruction. To our knowledge, other reported patients have had mild clinical disease, without resting hypoxemia. This patient is unusual because of the severity of her symptoms and hypoxemia, despite normal expiratory airflow. This patient demonstrates that although emphysema and airflow limitation commonly occur together, they are actually separate disease processes.

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Industry and Professional Medical Societies

To the Editor:

I share the concerns of Varkey, as given in “Time for Introspection” (April 2001). While commercialism is rampant in all aspects of our society, it is imperative to look at ourselves as a profession. But what should be done?

I have attended annual meetings of the American College of Chest Physicians, the American Thoracic Society, and other professional societies. I do think that the American College of Chest Physicians, in particular, has done an excellent job in disseminating the information and continuing medical education (CME) that are absolutely necessary for any practicing physician, and the Accreditation Council for Continuing Medical Education has fulfilled the mission as stated.

But should decisions be based on idealism alone? Should we ban all advertisements and/or sponsorship of any CME once and for all? What do the members of the American College of Chest Physicians think about the total banning of all sponsorship? My brief anecdotal experience suggests otherwise. Idealism may dictate that banning all sponsorship by pharmaceutical agencies will look good in the public view; but pragmatically, survival of CME programs at the current stage may not be feasible.

Why should we scorn the pharmaceutical industry? Are we angry at (jealous of) the huge profits of the pharmaceutical industry? Before we start criticizing the industry as whole, we should look at the enormous cost of bringing a single drug to the market. Extraordinary medical and legal implications have clearly made it impossible to bring drugs to the market at a far lower cost. Finally, it is the society, as defined eventually by the acts of Congress, that would decide the future of both medicine as well as the pharmaceutical industry. It is time for all of us in the medical profession not to view the pharmaceutical industry as a rival but as a necessary partner in health care.

Let me list the minimum necessary memberships and subscriptions (in my opinion) for a pulmonary critical care physician: American College of Chest Physicians, American Thoracic Society, American Medical Association, American College of Physiciansarrow, Society of Critical Care Medicine, New England Journal of Medicine, county and state licensing, etc. How many pulmonologists, intensivists, and internists, in these days of Health Care Financing Administration regulations and high overhead costs, would be willing to take over all the memberships and journal costs. (Those journals, of course, would not take any advertisements from drug companies in any form!)

I believe that anonymous reader surveys will be the best approach for this controversy. The adage “to lean neither to the left nor to the right, but to remain in the center,” is probably best for the American College of Chest Physicians.

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Discrepancies Between Clinical and Autopsy Diagnoses in Cases of Malignant Neoplasm

To the Editor:

We read with interest the retrospective autopsy report review of cases from a medical ICU by Tai et al (February 2001).1 However, in regard to undiagnosed malignancies in autopsy-confirmed cases, we consider that it is difficult to accept their data from several points: 10 days of hospitalization seemed a short time to diagnose malignant tumors; Tai et al did not describe the diagnostic procedure in detail; and the patients who participated in their study appeared to be younger than average for malignancies. Thus, to investigate discrepancies between clinical diagnoses and autopsy findings in malignancies, the data of hospitals treating patients of various ages, and with not only emergent diseases but also chronic ones, may be more reliable.

We previously reviewed 445 consecutive malignancies diagnosed by postmortem examination from 1988 to 1997 to elucidate discrepancies between clinical diagnoses and autopsy findings.2 Our rate of undiagnosed malignancies was 11.2% (50 of 445). These malignancies included 16 thyroid cancers, 10 prostate cancers, and 10 colon cancers (unpublished data). These undiagnosed malignancies consisted of 46 class-2 errors and 4 class-1 errors according to the review criteria by Tai et al (unpublished data). In the hospital we review, in cases of suspected malignancy, a systemic medical workup including chest and abdominal radiographs or ultrasonography is generally performed. Many of the patients present with a relatively high performance status, and complete medical workups can be carried out over a 2-week period or longer. In conclusion, we want to emphasize the importance of autopsy, because >10% of malignant neoplasms remain undiagnosed despite advances in medical technology.

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Non-small Cell Lung Cancer in Very Young and Very Old Malaysian Patients

To the Editor:

We read with great interest the article by Kuo et al (February 2000)3 on non-small cell lung cancer (NSCLC) in very young and very old patients. This, together with the paucity of information on lung cancer in very young and very old Asian patients,4–6 has prompted us to share our data on these patients. We reviewed the clinicopathologic data of patients with histologically and/or cytologically confirmed primary lung cancer diagnosed at our medical center, a tertiary teaching hospital, from October 1991 to September 1999. Of 510 patients with NSCLC diagnosed during this period, 32 patients (6.3%) were <40 years old (the young group) and 14 patients (2.7%) were >80 years old (the elderly group; Table 1). There was no difference in the male-to-female ratio between the young, middle-aged (40 to 80 years), and elderly groups. A significantly smaller proportion of young patients smoked compared to the other two groups. Compared with the elderly group alone, the proportion of smokers in the young group was also smaller. However, this was not statistically significant (two-tailed Fisher’s Exact Test, p = 0.054). Adenocarcinoma was the most common cell type in all three age groups, but it was significantly more common in the young group. There was, however, no significant difference in the proportion of adenocarcinoma between the young and the elderly groups. Metastatic (stage IV) disease at presentation was significantly more frequent in the young patients. When compared with the elderly patients, a higher proportion of young patients presented with stage IV disease (two-tailed Fisher’s Exact Test, p = 0.010). Of the three groups, a significantly higher proportion of young patients had poorer performance status at presentation. However, there was no significant difference in the level of performance status at presentation between the young and elderly patients.

Therefore, unlike the report by Kuo et al,1 we did not find significantly more female patients or more instances of adenocarcinoma in very young patients when compared with very old patients. Also, unlike the report by Kuo et al,3 we found our very young patients to have more advanced disease at presentation.

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