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Cryptogenic Hemoptysis and Smoking

To the Editor:

Boulay et al (August 2000)1 showed that hospitalization for hemoptysis followed a seasonal pattern: the distribution of cumulative monthly hospitalizations for hemoptysis peaked in early spring and was lowest in summer. In their report, hospitalization for cryptogenic hemoptysis did not statistically differ from hospitalization for noncryptogenic hemoptysis in seasonal variation. Therefore, the hypothesis of infection being the most frequent cause of cryptogenic hemoptysis is dismissed.

A total of 42.2% of all hemoptysis cases were classified as cryptogenic in their article, a percentage that is markedly high compared with other previously published articles. CT scanning (often high-resolution CT) together with chest radiography and fiberoptic bronchoscopy has recently been performed to diagnose hemoptysis. Hirshberg et al2 reported a 93% diagnosis rate for hemoptysis using fiberoptic bronchoscopy together with CT. Even in a previous study, where CT was not used in the analysis, only 3 to 22% of all hemoptysis cases were classified as cryptogenic.2 Although the study by Boulay et al1 was multicenter with a large number of patients, their study design was retrospective and diagnostic procedures differed among institutions. Noncryptogenic hemoptysis may have been classified as cryptogenic because cryptogenic hemoptysis is an exclusive diagnosis. Boulay et al1 did not comment about the amount of expectorated blood for indication of hospitalization, so biases of disease may not have been limited among institutions.

Boulay et al1 also did not comment about smoking in their article. Adelman et al3 reported that 71.6% of cryptogenic hemoptysis patients were smokers, although they did not discuss enough about the causal relationship between cryptogenic hemoptysis and smoking. We have observed 51 hospitalized patients with hemoptysis from 1995 through 2000 in Kure Kyosai Hospital (the volume of expectorated blood was 20 to 500 mL/day). Six hemoptysis patients (12%) were considered cryptogenic according to the findings of CT and fiberoptic bronchoscopy. Four patients were men, and two patients were women. Almost all patients were middle-aged men, except for an 83-year-old man. Nineteen of 51 patients were smokers, although they did not discuss enough about smoking. Endobronchial appearance was normal except for bleeding. Four patients had bleeding from the upper lobe, and two patients had bleeding from the middle lobe or lingular segment. CT showed only local pulmonary opacity, which was compatible with bleeding. After discharge, four patients ceased smoking and two continued, but none relapsed. We think smoking is one of the causes of cryptogenic hemoptysis. Cryptogenic hemoptysis and smoking have not been adequately studied and further examination is needed.

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To the Editor:

We appreciate the comments of Hiyama and colleagues on our article in CHEST (August 2000). They stated that the percentage of cryptogenic hemoptysis (42%) was particularly high in our study compared with other previously published studies and with their own results (12%). The distribution of causes of hemoptysis differed greatly in different studies, depending on geographic setting, time, and design of the study, and patient inclusion (or exclusion) criteria. Hiyama and colleagues studied a clinical series of 51 patients hospitalized for hemoptysis during a 6-year period, with detailed information and prospective follow-up. In contrast, we performed a retrospective epidemiologic study, covering a broad population (6,349 subjects who had, during a 3-year period, received a discharge diagnosis of spontaneous hemoptysis, with less detailed information collected from a large electronic discharge data file. This also explains why we had no information on smoking history or on the amount of expectorated blood. Furthermore, in our study, patients were not selected, and our data file included all kinds of patients, regardless of their age, the completeness of the etiologic investigation, and the amount and/or duration of bleeding. It is possible that a small number of the cases could have been erroneously classified as cryptogenic hemoptysis, but it is noteworthy that, in the study by Adelman et al., cryptogenic hemoptysis was identified in approximately 30% of all patients.

In the second part of their letter, Hiyama and colleagues commented about smoking, but they did not specify whether they considered tobacco an etiologic factor or a triggering factor of cryptogenic hemoptysis. Indeed, as with coronary atherosclerosis, tobacco use could, with a long latent period, lead to the creation of an underlying lesion, or it could transform this underlying lesion to clinically detectable bleeding. Due to the small number of patients with cryptogenic hemoptysis (only six patients), any conclusions about the etiologic factors should be drawn very cautiously. Furthermore, among the 51 hospitalized patients described by Hiyama and colleagues, the percentage of patients with hemoptysis who smoked was low, and the status of smokers (history of smoking or current smoking) was not precisely specified. So it is possible that some of the nonsmoking patients may have stopped smoking in reaction to the respiratory disease that caused their hemoptysis (lung cancer, chronic bronchitis, bronchiectasis). An argument for the role of smoking follows a seasonal pattern identical to cryptogenic hemoptysis.

To the Editor:

We read with interest the editorial by Dr. Pingleton regarding manpower planning (August 2001). Twenty years of manpower studies not only have not yielded credible results but actually have led to incorrect policies. Dr. Pingleton notes that the recent Committee on Manpower of Pulmonary and Critical Care Societies (COMPACCS) report in the Journal of the American Medical Association, costing >$250,000, predicted the opposite of earlier studies. She attributes this to the reliance of previous studies on a panel of “experts” (who somehow overlooked the demographic bomb called the ‘baby boom’), and the use of both a computer model and a specific data survey in the current study.

We were disappointed to see Dr. Pingleton call for the societies to develop more strategies for physician workforce planning, as this will waste even more of their members’ money, and waste even more hundreds of hours of professionals’ time, time that would better be spent on patient care, research, or teaching.

The COMPACCS members and their component societies need to review Economics 101. As this report itself suggests, central planning—a tenet of Socialism—doesn’t work, for reasons that have been recognized for many years. No matter how brilliant the elite group of planners, no matter how great their intuition, and no matter how much data or how many periodic evaluations they can amass, they cannot possibly develop more strategies for physician workforce planning, since this money, and waste even more hundreds of hours of professionals’ time, time that would better be spent on patient care, research, or teaching.

The COMPACCS members and their component societies need to review Economics 101. As this report itself suggests, central planning—a tenet of Socialism—doesn’t work, for reasons that have been recognized for many years.

No matter how brilliant the elite group of planners, no matter how great their intuition, and no matter how much data or how many periodic evaluations they can amass, they cannot possibly substitute successfully for the function of the free market. Forcing residents into different subspecialty training programs to ensure their future ability to “obtain meaningful and gainful employment is doomed to failure. Workforce and trainee planning should be abandoned immediately as an idea that is outdated, unworkable, and out of touch with reality.

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