**Bronchodilator Reversibility to Albuterol Predicts Bronchodilator Response to Salmeterol**

To the Editor:

We read with interest the recent study by Fish et al (August 2001) showing that adding salmeterol to inhaled corticosteroid achieved superior control as compared to adding montelukast. However it is likely that the results were biased toward the long-acting β₂-agonist as patients were required as an inclusion criterion to have at least 12% increase in FEV₁ in response to albuterol. It is therefore perhaps not surprising that for the primary end point of morning peak expiratory flow (PEF), salmeterol exhibited significantly greater bronchodilator efficacy as compared to montelukast. It is also worth noting that both treatments significantly improved the primary outcome variable compared to baseline, and that even allowing for the biased inclusion criteria, there was only a 13 L/min mean difference in morning PEF. One has to question the clinical relevance of this mean difference of 13 L/min, given that the mean baseline value was 370 L/min, and that most PEF meters are calibrated to the nearest 10 L/min.

This study provides no information on other relevant clinical efficacy markers, such as protection against bronchoconstrictor stimuli in the presence of increased bronchomotor tone, using bronchial challenge techniques. For example, studies comparing salmeterol and montelukast as add-on therapy have demonstrated greater and more sustained protection against adenosine monophosphate or exercise challenge. Moreover, the addition of a leukotriene antagonist to concomitant inhaled corticosteroid therapy confers additive anti-inflammatory effects that are not seen with long-acting β₂-agonists.

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**Captain of the Ship**

To the Editor:

Azocar and Lisbon should be commended for attempting to chart a course through rough and shark-infested waters. It is unfortunate that in the United States, the sickest and most complex patients are frequently managed by those least qualified to provide such care. Those of us who have trained and practiced multidisciplinary critical care outside the United States look through the portholes in dismay. It would be considered unthinkable in the United States, for a physician with no formal training in the practice and principles of surgery to perform complex surgery; yet, physicians with almost no training in this highly specialized and unforgiving discipline are permitted to provide care to patients who are at the highest risk of dying.

It is impossible to practice “part-time critical care.” Critical care requires a full-time commitment; it is labor intensive, requiring long hours at the bedside with frequent and repeated evaluations of the patient, and the capacity to respond rapidly and decisively to emergencies. This is impossible for even the most dedicated private practitioner or surgeon to achieve, as most of their time is spent in their offices and/or operating rooms far from the ICU. Consequently, the practitioner “portions off” the patients’ care to a number of organ-specific subspecialists. This usually results in fragmented and conflicting treatment strategies. Furthermore, both accountability and responsibility are also partitioned off, with no physician assuming ultimate responsibility for the patients’ care. The patient then drifts aimlessly through treacherous waters, having either the physiologic reserve to swim back to shore, or being ultimately taken by the sea.

ICU patients should be managed by dedicated intensivists, be they of surgical or medical background, who have undergone specialized multidisciplinary training to provide them with the necessary knowledge, skills, and attitudes required to achieve the best outcomes for critically ill and injured patients. This is not to say the primary care physician or surgeon should be excluded from his or her patient’s care; they remain an important resource. It is but a sad reflection on medicine in the United States that it has taken industry to provide the impetus to steer our specialty on the right course. We believe that only trained and certified critical care specialists who spend at least 50% of their professional time practicing critical care medicine should be privileged to provide care in the ICU.

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