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Need for Broader Training in Sleep?

To the Editor:

I read with interest Dr. Collop’s editorial comments in the December 2001 issue of CHEST. She comments that the article by Krakow et al highlights the need for pulmonologists to receive broader training in aspects of sleep other than just obstructive sleep apnea (OSA).

My response to her comments is... why? My training in sleep began in a laboratory in the early 1980s, when the details of OSA were just beginning to be described. We had little interest in insomnia and never considered that the subject would be something that the pulmonary specialist would become involved with. As the years passed, the feeling grew that there was something odd about the concept that the same person who spends their morning treating sepsis and hypotension in the ICU should be the one to chat with an anxious young person about sleep hygiene in the afternoon. When I mention this nihilism to my colleagues, they view me in the same way that the villagers viewed the young boy who screamed out that the emperor had no clothes.

I remain perplexed as to why the pulmonary fellow often goes on to become board-certified in sleep medicine. It is a pathway that has become commonplace, with little rational thought supporting it. It is of course reasonable that the breathing disorders associated with sleep should be of great interest to us, and there is no discipline that is better suited to care for these patients than pulmonary medicine. However, there remains no natural connection between respiratory disorders and the vast majority of maladies that plague the sleepless individual, other than OSA.

David Posner, MD, FCCP
Lenox Hill Hospital
New York, NY

Correspondence to: David Posner, MD, Pulmonary Diseases, 178 E 85th St, New York, NY 10029

REFERENCES

1 Collop NA. Can’t sleep? You may have sleep apnea. Chest 2001; 120:1768–1769


To the Editor:

I thank Dr. Posner for his comments and appreciate the opportunity to respond. I first would like to point out that the article by Dr. Krakow et al (December 2001) suggested that many patients with sleep apnea present with symptoms of insomnia. This suggests that physicians, including pulmonologists, need to pay attention to insomnia complaints, as they may be a marker for sleep-disordered breathing (SDB). Additionally, although Dr. Krakow did not prove this in his study, one might surmise from his conclusions that patients who initially present with complaints of insomnia may have more difficulty in tolerating therapy with nasal continuous positive airway pressure and may require some more specific interventions for treatment of their insomnia.

On a broader scale, when patients come to a doctor with sleep complaints, they usually do not know what their diagnosis is. The vast majority of sleep laboratories in the United States are run by pulmonologists, many of whom do not have specific training in sleep medicine. Once a pulmonologist becomes a part of a sleep laboratory, he/she is then viewed as a sleep expert—how would a patient know the difference? I disagree that there is “little rationale” for a pulmonary fellow to become board-certified in sleep medicine. I think that since SDB is one of the most common sleep disorders and that since pulmonologists are the most logical specialists to take care of those patients, it follows that pulmonologists should run sleep laboratories, where 70 to 80% of the patients are being screened for SDB. But the sleep laboratory doctor cannot ignore the other 20 to 30% of patients who have sleep problems but do not have SDB! And in order to care for those patients, they need to have more expertise in sleep medicine.

Pulmonologists took over critical care because of respiratory failure and the use of mechanical ventilation. There is a specific body of knowledge that is required to be learned to practice intensive care medicine, much of which is not purely pulmonary. Sleep medicine is no different, and if pulmonologists want to diagnose and treat SDB patients, and run sleep laboratories, just like they do critical care units, they need to know the body of knowledge of sleep medicine. The analogy is no different.

Nancy A. Collop, MD, FCCP
University of Mississippi and Jackson VA Medical Center
Jackson, MS

Correspondence to: Nancy A. Collop, MD, FCCP, The University of Mississippi Medical Center, 2500 N State St, Jackson, MS 39216-4305; e-mail: ncollop@aol.com

REFERENCES