experimental and clinical studies are needed to establish definitive guidelines for the safe use of COX-2 inhibitors in AIA.

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REFERENCES


To the Editor:

We thank Dr. Ken-ichiro et al for their comments regarding our article that was published in CHEST (June 2002).1 After going through the content of the letter, we would like to highlight that aspirin-induced asthma (AIA) is not mediated by allergic mechanisms but by the shared pharmacologic actions of aspirin and other nonsteroidal antiinflammatory drugs (NSAIDs).2 So, the murine models of ova-albumin-induced bronchial hyperresponsiveness in mice with cyclooxygenase (COX)-1 and/or COX-2 knockout are not appropriate models of NSAID. We agree that the biosynthesis of cysteinyl leukotrienes is up-regulated in AIA, but it is not clear that large amounts of COX-2 inhibitor may cause deterioration of asthmatic symptoms in patients with AIA. Rofecoxib was found to be well-tolerated by AIA patients and did not appear to cause asthmatic attacks in patients with AIA and NSAID-induced asthma.

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REFERENCES


Talc Pleurodesis vs Iodopovidone

To the Editor:

The report by Olivares-Torres et al (August 2002)1 is an important first step in seeking a safe, inexpensive alternative method to talc for treating patients with pleural effusions by pleurodesis using iodopovidone. The numbers and results are quite similar to those in our 1991 report2 on thoracoscopic talc poudrage (TTP) in which we found a 100% success rate at 1 year when the occurrence of trapped lung was eliminated from the data (which Olivares-Torres et al did a priori). There were no instances of ARDS in our 39 patients or in 360 cases of TTP reported by my mentors.3

Since the calculated incidence of ARDS after talc is on the order of 1 in 700 to 1 in 140 patients,4 it would require a study involving thousands of patients treated with iodopovidone pleurodesis to prove that it is safer than talc pleurodesis. Doxycycline and bleomycin pleurodesis have been reported in relatively few patients compared to talc pleurodesis, yet both have been associated with catastrophic respiratory failure.3 Ideally, a prospective randomized study will be performed.

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The 9% incidence of ARDS referenced by Olivares-Torres et al4 actually occurred in patients who had undergone surgical procedures, including pleural abrasion and talc application, suggesting that pleural abrasion may be a risk factor for ARDS. But their 17 cases of simple talc poudrage were associated with no instances of ARDS.5

It is worrisome that severe hypotension and pain due to iodopovidone occurred in three of the five patients with mesothelioma. We did not encounter this phenomenon among the 26 mesothelioma patients who had received TTP.6
Olivares-Torres et al do not describe a simpler alternative to TTP. They injected iodopovidone in conjunction with thoracoscopy into 40 of the 52 patients (77%) in their study. They applied the iodopovidone under general anesthesia in 67% of their patients. General anesthesia is expensive, possibly hazardous, and has been shown to be unnecessary in performing TTP.2,3

TTP required a mean length of stay in our hospital of only 3.9 days.2 What was the length of stay in this study of iodopovidone?

The 30-day mortality rate after pleurodesis is often reported as > 10% due to the presence of advanced malignant disease and other comorbidities. The absence of any 30-day mortality rate in the series by Olivares-Torres et al suggests a very cautious selection of candidates.

Although the use of iodopovidone for pleurodesis presents an interesting possibility, this study does not justifiably injecting iodopovidone either via chest tube or via thoracoscope at this time, except in a prospective study protocol.

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REFERENCES
4. Sahn SA. Talc should be used for pleurodesis. Am J Respir Crit Care Med 2000; 162:2023–2024

To the Editor:

I thank Dr. Aelony for his comments on our article in CHEST (August 2002) and appreciate the opportunity to respond. There are a few points in his letter that need clarification.

1. Safety of talc. For decades, talc, whether by poudrage or slurry, has been considered to be the most effective pleurodesis agent available.2 Unfortunately, there is growing concern regarding the safety of talc administered intrapleurally.3,4 In his letter, Dr. Aelony states that the calculated incidence of ARDS in patients undergoing talc pleurodesis ranges from 0.14 to 0.07% (ie, barely 1 case of ARDS per 1,000 patients treated with talc pleurodesis). However, in the editorial used as reference for these data,2 the author actually presents an estimated incidence of 7 cases of ARDS per 1,000 patients treated with talc pleurodesis. As we mention in our article, the reported rate of ARDS associated with talc pleurodesis has been as high as 9%. There are at least 32 cases in the literature of ARDS occurring after the administration of intrapleural talc. In eight instances, the patient died.3 It seems that an important factor in the development of ARDS associated with talc pleurodesis is the size of the talc particle.5 Although the risk of mesothelioma from talc pleurodesis is very small, the fact that the possibility exists provides another reason not to use talc for pleurodesis, especially in nonmalignant conditions. Iodopovidone has been extensively used in Mexico for almost 10 years without reports of any serious side effects. Obviously, it should not be used in the presence of a bronchopleural fistula. Its passage into the bronchial tree could be associated with the development of ARDS, due to the low pH of talc.

2. Pain and hypotension. Dr. Aelony expresses concern over the report that three of our patients experienced severe pain and hypotension. The use of any effective pleural irritant, including talc, can and will produce intense pleuritic pain (and a vasovagal reaction) if analgesia and anesthesia are inadequate. The control of pain should be individualized, especially in patients with neoplastic diseases, who already are receiving high doses of narcotic analgesics.

3. Need of thoracoscopy. Thoracoscopy was performed in 40 of our 52 patients with the purpose of obtaining pleural tissue for diagnosis. When malignancy was reported, pleurodesis with iodopovidone was performed at the end of the surgical procedure. However, pleurodesis with iodopovidone can be perfectly and successfully carried out through a tube thoracostomy. The median length of stay in the hospital after pleurodesis was 2 days.

4. Iodopovidone should not be used, except in a prospective study protocol. A controlled clinical trial of pleurodesis using iodopovidone in the study group, and talc in the control group, would involve the use of a substance (talc) that has been associated with a highly lethal complication (ARDS) vs another equally effective substance not yet associated with any serious complications. Besides the ethical dilemma for the investigators, undoubtedly it would be extremely difficult to obtain written informed consent from potential participants.

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References
2. Sahn SA. Talc should be used for pleurodesis [editorial]. Am J Respir Crit Care Med 2000; 162:2023–2024
3. Light RW. Talc should not be used for pleurodesis [editorial]. Am J Respir Crit Care Med 2000; 162:2024–2026