group (in-hospital mortality rate, 25%). Thus, we believe that patients with signs of myocardial injury should be considered as potential candidates for aggressive therapy. However, a multicenter, prospective, randomized trial is needed to address the clinical value biomarkers and to define their optimal levels in a management strategy of patients with submassive APEs.

To the Editor:

Surgery in Lung Cancer Patients

To the Editor:

Medical academic journals are influential in physicians' decision making all over the world. In the July 2002 issue of CHEST, Handy et al. showed that the quality of life of patients is impaired 6 months after lung cancer resection. Another article2 and an editorial3 properly has indicated the specific use and the economical interests that underlie screening.

After all this reading, should the practitioner deny surgery to his patients? Does it make sense to conclude that a patient's quality of life is suboptimal 6 months after undergoing surgery when lung function and residual pain can still improve?

Historically, the Mayo Lung Project did not show a significant difference in survival between resected patients who had been tested for detection three times a year and their usual population of heavy smokers (control group) who were tested every year. In those days, Dr. Robert Fontana (personal communication; July 9, 1984) wrote me the following: "I deeply appreciate the data that you sent to me, and I agree with you completely. The data are impressive, particularly the overall resectability rate of approximately 15%. Our final figures concerning resectability in the Mayo Lung Project are now 32% for the control group. Nearly a third of the cancers in the control group were detected by chest radiograph films obtained during the evaluation of non-lung cancer complaints or during general medical examinations of men who had been heavy smokers. Of lung cancers detected in this way, 75% were resectable 'for cure.' Such cases constitute the majority of resectable cases in the control population. I believe that you have supplied the answer to the question of what would have happened to the patients in the control population had they not access to chest radiograph examinations."

There are important differences between studies involving large populations and the responsibility of each physician to the individual patient, the source of the physician's duty and concern. So, I believe that, to date, the best indication for a high-risk patient is early endoscopic and/or CT scan detection of lesions. The patient will then be able to take the unique chance for a cure that only surgery can offer.

Hugo Esteva, MD, FCCP
Hospital de Clínicas, University of Buenos Aires
Buenos Aires, Argentina

Looking at Transpulmonary Thermodilution Curves

The Cross-Talk Phenomenon

To the Editor:

Transpulmonary thermodilution has been shown to be an easy and reliable technique for hemodynamic monitoring in critically ill patients and is being used increasingly.1-4 After injection of a
Looking at transpulmonary thermodilution curves can be very useful to diagnose intracardiac shunts. However, a cross-talk phenomenon may result in a double-hump thermodilution curve wrongly suggestive of right-to-left intracardiac shunting. Therefore, the use of venous and thermistor-tipped arterial catheters on the same side and of the same length should be avoided in patients monitored with transpulmonary thermodilution.

Frédéric Michard, MD, PhD
Massachusetts General Hospital-Harvard Medical School
Boston, MA

Is the Recommendation Not To Use Rifampin Plus Pyrazinamide for Latent Tuberculosis Treatment Always Imperative?

To the Editor:

Following several reports of severe liver injury, the American Thoracic Society and the Centers for Infection Control and Prevention recently recommended to discontinue the use of rifampin plus pyrazinamide (RZ) as treatment for latent tuberculosis (LTB). Considering the limited choice of drugs proven effective for this purpose, in our opinion this advice, though judicious and precautionary, is a cause of major concerns. In the United States, the implementation of mandatory screening and treatment for LTB in immigrants from high-prevalence countries actually encounters relevant difficulties because of the variable isoniazid (INH) resistance patterns among different countries, and of possible severe hepatotoxicity associated with antituberculosis drugs. High primary INH resistance rates have been registered among immigrants from Vietnam, South Korea, Haiti, the Philippines, and China. In fact, a decision analysis model

References