
To the Editor:

We thank Dr. d’Orbcastel for his update on the evolution of the French system of home care for patients with respiratory insufficiency. He reflected on the key role that Dominique Robert played in the initiation and development of the French system, and commented that, “such pioneering is more difficult today with budget restrictions and immediate value for money being demanded.” How our societies will support and encourage innovation as we seek cost-effective systems that will increase the quality of life for people with chronic disabilities remains a fundamental question for the future. The interactions between publicly financed and privately financed medical care organizations and the academic enterprise are complex, and, to our knowledge, have not been thoroughly worked out in any industrialized nation. While private enterprise has the potential to encourage innovation and to develop new and more cost-effective paradigms for the delivery of care, there is also the very real potential that privately financed medical systems will seek to “cream” the less complex and less severely afflicted patients. Thus, the public sector is at risk for being left with the care of only the patients with the most costly conditions. In addition, the private market is limited as a mechanism for promoting innovations because of the low profit potential, which can be a problem with technology that is designed for small, highly specialized markets of disabled consumers, who are more likely to be unemployed or living on low fixed incomes when compared to the general public.

In this context, we have found that a central database like the ANTADIR Observatory offers policy makers and program managers a valuable tool in the cost-effective management of care for people with chronic diseases. There is a saying drawn from business experience in the United States: “If you can’t measure it, you can’t manage it.” Given the value of your database as a management tool, perhaps financial incentives can be offered to the doctors “in the field” to encourage them to provide the data. This type of approach has proved to be beneficial in the United States, where it is recognized that one of the fundamental conditions for an “efficient marketplace” is good data.

We wish you the very best as you rise to the challenges of changing conditions.

Mary Stuart, ScD
University of Maryland, Baltimore County
Baltimore, MD

Underuse of Spirometry in Primary Care

To the Editor:

We read with great interest the article recently published by Buffels et al in CHEST (April 2004).1 According to the authors, spirometry in general practice is feasible to perform and is sufficiently accurate. In addition, spirometry allows us to establish diagnoses of COPD and asthma in patients with formerly unknown obstructive lung disease (OLD). The authors concluded that the use of spirometry is mandatory if the early stages of OLD are to be detected in a general practice, since it is quite probable that the majority of the patients with unidentified COPD first consult with a general practitioner (GP). In the experience of Buffels et al,1 screening for airflow obstruction, doubled the number of patients known to have OLD.

However, reality is quite different. In our health system, spirometry is a technique that is largely unknown in primary care centers. In an urban area that depends on our teaching hospital for health care, there are 24 primary care centers attending a population of 700,000 inhabitants. Previous studies2 have demonstrated a COPD prevalence of 9% among people 35 to 60 years of age in our country, of whom 78% are unaware that they have the disease. Despite this situation, only 18 centers have spirometry equipment, 3 of which do not perform spirometry at all. The remaining centers perform an average of two spirometry procedures per week. It is evident that, as a result, there is a loss of motivation to perform spirometry and a loss of sensitivity in using this useful and necessary diagnostic tool on the part of the GP.

It is clear that it is important to receive adequate respiratory training in general practice, including aspects of the diagnosis and management of asthma and COPD, as well as training in the performance of spirometry and the interpretation of its results. Health authorities must be sensitive to this problem and must provide continuous technical and methodological support to the GP. Primary care doctors should be stimulated to search for patients with OLD that is in the early stages, and to take the results of spirometry into account.

Salvador Díaz-Lobato, PhD
Sagrario Mayoralas, MD
Hospital La Paz and Hospital de Móstoles
Madrid, Spain

References

To the Editor:

We agree with the authors that spirometry remains an unknown technique to a majority of general practitioners. Microspimeters that enable the widespread use of office spirometry are a relatively new phenomenon. Until now, only a few studies have tested the accuracy and the reliability of these devices. The technique is probably too recent to reach a generalized use in primary care.

Furthermore, in several countries, the performance and the interpretation of lung function tests are not included in the basic training of general practitioners. The potential importance of spirometry has probably been underestimated until now. We agree with Salvador Díaz-Lobato that adequate respiratory training should be encouraged for primary care physicians. This could optimize early detection and appropriate care for patients suffering from asthma or COPD. In Belgium, we are starting with
specific training in office spirometry, in a joint group of pulmonologists and general practitioners. We will report later about the effects of this project.

Johan Buffels, MD
Academisch Centrum voor Huisartsenpraktijken
Leuven, Belgium

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Correspondence to: Johan Buffels, MD, Academisch Centrum voor Huisartsenpraktijken, Kapucijnenvoer 33 blok J, B3000 Leuven, Belgium; e-mail: johan.buffels@coditel.net

Malignant Pericardial Effusions

To the Editor:

Dr. Cullinane et al. report on the surgical management of malignant pericardial effusions. Surgical intervention is advocated with the caveat that “there are a number of different interventions ranging from catheter drainage to subtotal pericardietomy available to clinicians seeking to offer palliation.” However, he does not discuss in his article, nor cite in the references, pericardial catheter drainage with intrapericardial sclerosis, which is a minimally invasive low-cost procedure just as effective and obviously less morbid than a pericardial window, either by anterior lateral thoracotomy, video thoracoscopic, or subxiphoid approaches. It has essentially replaced surgical drainage in many thoracic oncologic practices. Although pericardietomy may be required for constrictive pericarditis, benign pericardial effusions, or as a diagnostic biopsy, its use for malignant pericardial effusion is probably unnecessarily invasive.

Kenneth M. Frankel, MD, FCCP
Baystate Medical Center
Springfield, MA

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Correspondence to: Kenneth M. Frankel, MD, FCCP, Baystate Medical Center, 2 Medical Center Dr, Suite 304, Springfield, MA 01107; e-mail: kenneth.frankel@bhs.org

REFERENCES


To the Editor:

Dr. Frankel has chided us for not including more information and references on percutaneous pericardial drainage and chemical sclerosis (PPDS). The reality of limitations on word count and citations required to keep journal articles of reasonable length make it impossible for authors to satisfy all readers. We did include the largest published series of pericardial drainage cases from the Mayo group, as well as three other references, and have discussed the relative merits of these techniques in more detail elsewhere.

Although Dr. Frankel believes that PPDS is “just as effective and obviously less morbid” as well as less expensive than surgical techniques, there are only 140 patients in the three series he cites. Even in experienced hands, guided by echocardiography, there is a substantial risk of cardiac penetration during pericardiocentesis. Technical failure, pain, dysrhythmia, fever, infection, and cardiac arrest are described as complications of PPDS. Prolonged hospitalization is required for drainage of fluid and repeated sclerosant injections. Only 75% of effusions were controlled for >30 days, and median survival periods were only 98 days, 97 days, and 30 days in the series cited. These articles do not provide information on the success of this treatment in preventing recurrent pericardial effusion and tamponade beyond 30 days.

We have provided information documenting a very low rate of pericardial effusion recurrence following surgical window techniques, including thoracoscopic pericardial window, based on a careful standardized follow-up protocol including monthly clinical examination, chest roentgenograms, and/or echocardiograms. This information can be used as a historical control in future PPDS studies. Perhaps with increased experience and refinement of techniques, PPDS may achieve equivalent success with surgical window drainage. The best approach to resolve this question will be a prospective study of surgical window vs PPDS.

Frederic W. Grannis Jr., MD
Carey A. Cullinane, MD
I. Benjamin Paz, MD
City of Hope National Medical Center
Duarte, CA

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Correspondence to: Frederic W. Grannis Jr., MD, FCCP, Head, Section of Thoracic Surgery, City of Hope National Medical Center, 1500 East Duarte Rd, Duarte CA 91010; fgannis@coh.org

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