unconventional indications, we will be permanently handcuffed in using this potentially life-saving therapy. Furthermore, we believe that it is our ethical duty to add our single case report to the existing body of literature and would like to remind Drs. Kirby and Lobato that there has been a case series and several sporadic case reports describing the use of ECMO in both the pediatric and adult populations for respiratory failure secondary to DAH.

We think that Dr. Weber’s editorial3 does not advocate the indiscriminate use of ECMO in the patient with DAH and that there is an emphasis on the very real complication of fully anticoagulating a patient with preexisting hemorrhage. Fortunately, most patients with DAH can be maintained with conventional mechanical ventilation. In conclusion, we agree with Dr. Weber that “ECMO should at least be considered for all patients with potentially reversible pulmonary failure” when conventional therapy fails, “even if there is little or no literature support and common sense argues against its use.” We contend that this is the art of medicine.

Kristin B. Highland, MD, FCCP
Medical University of South Carolina
Charleston, SC

REFERENCES
3 Weber TR. Extending the use of ECMO [editorial]. Chest 2004; 126:9–10

Obesity in ICU Patients
Increase or Decrease in Mortality?

To the Editor:

We read with interest the article by Goulenok et al in a recent issue CHEST (April 2004),1 showing that obesity, defined by a body mass index (BMI) > 27, was associated with a higher mortality rate among ICU patients than predicted by the simplified acute physiology score (SAPS) II. The authors were surprised by the fact that overweight was not taken into consideration by the SAPS II or APACHE (acute physiology and chronic health evaluation) score. Four other studies2–5 have analyzed the potential impact of obesity on ICU outcome, with conflicting results. Like Goulenok et al1 two of these studies2,5 showed increased mortality in obese ICU patients. However, in one of these studies,2 the obese patients had a particularly high mean BMI of 51, and were compared to a group of nonobese patients (BMI < 30). The authors did not give their results for patients with BMI values between 30 and 40. Tremblay and Bandi3 found no difference between overweight and severely obese patients in a multi-institutional database of 41,011 ICU patients. Furthermore, Garroute-Orgeas et al4 found a lower mortality rate in obese ICU patients (BMI > 30) than in nonobese patients. We conducted a prospective, multicenter, case-control study to evaluate the prognostic significance of BMI > 35 in ICU patients receiving mechanical ventilation for > 48 h. Our preliminary results for 69 patients with a mean BMI of 42 ± 6 and a mean ((± SD) SAPS II score of 45 ± 15 show that mortality was lower than predicted by SAPS II (16% vs 37%, respectively), with a standard mortality ratio of 0.46. These results disagree with those of Goulenok et al1 even though they were obtained in patients with higher BMI values and poorer clinical status (SAPS II) on ICU admission. Thus, the impact of obesity in ICU mortality remains controversial, and it seems premature to add BMI to ICU severity scores.

Jean-Pierre Frat, MD
Association des Réanimateurs du Centre Ouest
Poitiers, France

REFERENCES
3 Tremblay A, Bandi V. Impact of body mass index on outcomes following critical care. Chest 2003; 123:1202–1207