Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Please submit letters online at http://mc.manuscriptcentral.com/CHEST. Please include a cover letter with a complete list of authors (including full first and last names and highest degree), corresponding author’s address, phone number, fax number, and e-mail address (if applicable). Specific permission to publish should be cited in the cover letter or appended as a postscript. CHEST reserves the right to edit letters for length and clarity.

通讯作者

ABSTRACT

Scientific Value of Parenteral Fluids Data

To the Editor:

It is unfortunate that Dr. Bauer took my letter to be an argument ad hominem. It was not. It was consistent with his own observation on the generally confused posture of the profession on treatment for nosocomial pneumonia.

Recognized authorities had previously noted the unsatisfactory status not only of our treatment but of our fundamental understanding of the problem. Dr. Bauer makes the assertion that there are no studies in the literature supporting my view that excessive parenteral salt and water is a basic problem in the development of nosocomial pneumonia, “to his knowledge.” In fact, there is quite a lot of information on acute development of ARDS/nosocomial pneumonia, “to his knowledge.” Dr. Bauer makes the assertion that excessive parenteral salt and water is a basic problem in the development of nosocomial pneumonia, “to his knowledge.” In fact, there is quite a lot of information on acute development of ARDS/nosocomial pneumonia, “to his knowledge.”

In fact, there is quite a lot of information on acute development of ARDS/nosocomial pneumonia, “to his knowledge.”

William S. Lyons, MD
Falls Church, VA

References

1 Bone RC. Why sepsis trials fail. JAMA 1996; 276:565–566
3 Chernow B. Back to the drawing board. Crit Care Med 1996; 24:1097–1098

REFERENCES

1 Bone RC. Why sepsis trials fail. JAMA 1996; 276:565–566
3 Chernow B. Back to the drawing board. Crit Care Med 1996; 24:1097–1098
with left heart failure, and fluid supplementation needs to be closely monitored in all our patients.

Torsten Bauer, MD
Klinikum der Ruhr-Universität
Bochum, Germany

Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (e-mail: permissions@chestnet.org).

Correspondence to: Torsten Bauer, MD, Medical Clinic III, Bergmannsheil, Ruhr University, 44789 Bochum, Germany; e-mail: torsten.bauer@rub.de

REFERENCES


Influence of Overweight on ICU Mortality

A Prospective Study

To the Editor:

We read with interest the prospective study of the influence of overweight on ICU mortality by Goulenok and colleagues1 in CHEST (April 2004), and noted the provocative findings and conclusions that obesity is an independent prognostic variable in ICU mortality. Despite the fact that the perception of obesity as a mere overfed state with excess energy storage in the form of fat is no longer sustainable in modern medicine, the insidious ramifications of the overfed model continue to permeate the management and epidemiologic research on obesity. The shortcomings of the body mass index as a measure of obesity are emphasized by the fact that the individual metabolic and physiologic aberrations that are common in obesity, such as impaired glucose metabolism2 and cardiopulmonary dysfunction, are by themselves significant independent variables in ICU mortality. Thus, unifying the term overweight under the rubric of body mass index grossly deflects our observations from the pathologic components of the obesity syndrome, which have an independent impact on mortality.

Jeevanandam et al3 observed that protein-energy malnutrition rapidly ensues among obese trauma patients, which is strongly suggestive of the fact that hypoproteinemia may be a regular feature among physiologically stressed obese individuals. An extrapolation of this observation includes the postulation that the stressed obese patient is in a malnourished state with the possibility of coexisting derangements in the utilization of or overt deficiencies of vitamins, metabolic cofactors, and minerals that may lead to suboptimal function under the high metabolic demands of critical illness. Yet, documentation of the nutritional status of the obese subject is distinctly sparse in the medical literature on the subject.

Perhaps significantly, the study did not report on the distribution of comorbid conditions such as hypertension, diabetes, depression, psychoneurotic illnesses, and sleep-disordered breathing that are encountered with increased frequency among obese subjects. If present, the multiple comorbid factors by themselves may be independent confounders of the observed mortality, besides being associated with the use of multiple medications, the potential of which toxicity in patients with critical illnesses is high due to a diminished drug clearance capacity.

While analyzing the mortality data for obese patients in the ICU, we should not neglect the fact that obesity is predominantly a disease of persons in the lower socioeconomic classes,4,5 whose utilization of health resources prior to hospitalization is marginal, and who are also known to have higher hospital mortality from cancer, cardiac disease, and major surgery owing to poorly explained factors.6,7

To the skeptic, a multifactorial condition such as obesity that has poorly characterized nutritional derangements, and a tendency for glucose impairment and complex cardiopulmonary disturbance, and is frequently associated with multiple medical problems does not measure up well as an independent determinant of mortality in the ICU without controlling for the associated factors.

Daniel S. Dube, MD
Stanford University Medical Center
Stanford, CA

REFERENCES


Overweight in ICU Patients

Is the Body Mass Index Reliable?

To the Editor:

In a prospective study, in order to examine the relationship between body mass index (BMI) and mortality among ICU patients, Goulenok et al1 found obesity (ie, BMI > 27) to be associated with a poorer clinical outcome. Surprisingly, their results are in contrast with the results from other investigations.2,3 Goulenok et al1 reported that body weight and size were measured for all patients. Importantly, the investigators measured weight and height, instead of estimating these parameters, to calculate the BMI.4 However, we still have some doubts about whether the BMI was calculated adequately in all study subjects.

www.chestjournal.org