If weight was truly measured in all patients, did the investigators adjust weights for fluid balances? This is not a trivial comment. The most severely sick patients (i.e., those with the greatest risk for death) frequently need more fluids (especially when saline solutions are used for fluid therapy). This raises the total measured body weight and, thus, the BMI. Hence, BMI could be a confounder in this study.

Let us give two examples to illustrate the problem. After therapy with 7 L fluid, a person with a height of 6 feet 3 inches and a weight of 205 lb will have a BMI of 27.5, instead of 25.6, and a person with a height of 5 feet 11 inches and a weight of 183 lb will have a BMI of 27.6, instead of 25.5. Thus, more severely sick patients might become “obese” because they are sick.

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References

To the Editor:

We thank Dr. Dube for his very interesting comments about our article (April 2004). Indeed obesity is associated with physiologic and metabolic aberrations, such as impaired glucose metabolism, or comorbidity, such as hypertension, depression, or psychoneurotic illness. These factors probably play a major role in the increased mortality of this specific population as they are well-known factors affecting glucose metabolism in ICU patients. Unfortunately, we did not collect these data in our patients. We now would like to perform a multicenter prospective study that would aim to identify comorbidity factors that may be associated with the increased mortality observed in overweight ICU patients. Likewise, it would probably be interesting to register patients’ socioeconomic status as that may also interact with outcome. We fully agree with Dr. Dube that individualizing these factors probably will help doctors to provide specific care for overweight ICU patients. In this setting, body mass index (BMI) is an easy variable to collect in any ICU patient and could be used as an alarm for practitioners.

We also thank Drs. Schultz and Spronk for their very interesting comments about our article. To our knowledge, there are actually not just two but nine published articles including our study, that have analyzed the influence of overweight in ICU patients. The contradictory results provided by these different publications can be explained in part by differences in the terms used to study this population, and also by the timing and methods used for the evaluation of BMI. The large preponderance of different diseases in our study population (94.3%) probably influenced our results compared to those of other studies. Weight and size were measured for all patients at the time of ICU admission and that may also constitute a difference with the other published studies. We also tried to minimize the influence of fluid loading therapy administered soon after ICU admission. On the other hand, volume depletion (i.e., diarrhea, bleeding, vomiting, and diuretic treatment) was not taken into consideration in the calculation of BMI. The effort to integrate the amount of volume depletion and fluid therapy into the estimation of body weight is probably too difficult. The early measurement of BMI at ICU admission actually seems to be the best and easiest method for minimizing the influence of these factors.

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Endobronchial Endometriosis Nd-YAG Therapy vs Drug Therapy

To the Editor:

I read with great interest the selected report by Puma et al in a recent issue of CHEST (September 2003). They described a...
case of endobronchial endometriosis that was successfully treated by Nd:YAG laser therapy. However, I would like to suggest that pulmonary endometriosis is probably less rare than is commonly thought, as I have counted 104 cases of tracheobronchial or pulmonary endometriosis as a result of searches of the medical literature (including 23 cases published in languages other than English). Some of these cases presented evidence such as a pattern of lung opacities or necropsy findings and not catamenial hemoptysis. I also think that Nd:YAG laser therapy could be useful for the treatment of endobronchial endometriosis only when drug therapy is not effective, or when the adverse effects of this drug therapy are intolerable, as this procedure is associated with a certain morbidity. Although the risk of general anesthesia is considered to be low, hypoxemia, hypercapnia, and acidosis secondary to apneas, and the reduction of ventilation are presumed to be the major causes of intraoperative and postoperative complications. Cardiac arrest due to ventricular fibrillation may occur during rigid bronchoscopic laser therapy even in young patients with benign bronchial lesions. The authors maintained that “Medical therapy has been recommended as the first choice in pulmonary endometriosis. It consists of the suppression of endometrial tissue with progesterone (ie, pseudomenopause) or danazol (ie, pseudomenopause).” I partly agree with this statement, as the authors failed to mention that gonadotropin-releasing hormone agonists have been prescribed for >10 years and are effective in the treatment of this disease, as in our published case. Finally, I think that the follow-up period was not sufficiently long enough to ensure that the treatment was permanently effective. Unfortunately, the authors did not mention whether follow-up fiberoptic bronchoscopy was performed during menses.

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REFERENCES


To the Editor:

We read with interest the letter by Dr. L’Huillier regarding our article, “Successful Endoscopic Nd-YAG Laser Treatment of Endobronchial Endometriosis,” published in CHEST (September 2003). The rarity of central airway endometriosis and the difficulty of a clear demonstration of the bronchial lesion, until now, has hampered local therapy for this condition. In our patient, the bronchial lesion was conclusively located by spiral CT scan and fiberoptic bronchoscopy, which were obtained at the onset of menses. In such a fortunate case, the simple endoscopic Nd-YAG laser vaporization of the previously recognized target led to the patient’s immediate and stable recovery. The patient is still asymptomatic after a follow-up period of 34 months, which we consider to be a good long-term outcome. The patient’s condition was controlled at the onset of menses with fiberoptic bronchoscopy 3 months after treatment, with normal endoscopic findings.

Dr. L’Huillier emphasizes the risk of general anesthesia and rigid bronchoscopic laser therapy. Worldwide, thousands of such procedures have been carried out with low risk, even in desperate situations such as in patients with critical tracheal stenoses. We have extensive experience in rigid bronchoscopic laser therapy of tracheobronchial obstructions in >1,200 consecutive cases with a mortality rate <0.1% (in an emergency procedure for impending asphyxia). For this reason, in the reported case, we preferred to use the ventilating rigid bronchoscope under general anesthesia, mainly to obtain a steady target and to more precisely deliver the laser beam. Nevertheless, we clearly stated that the procedure “could have been performed through the flexible bronchoscope” with local anesthesia in an outpatient setting. Hormonal therapy is effective in curing or controlling symptoms, however:

1. It needs to be maintained for a long period of time;
2. There is a variable recurrence rate after drug therapy is discontinued;
3. Heavy side effects can be observed.

We respect our colleague’s opinions, but we think that some concepts in Dr. L’Huillier’s letter overlook an obvious point. Unquestionably, a single course or even multiple courses of bronchoscopic laser therapy are preferable to prolonged hormonal therapy with its possibly heavy side effects and uncertain results. The problem of local therapy for this condition is related to the difficulty of conclusively locating the bleeding source in the tracheobronchial mucosa.

Finally, a clear-cut distinction should be maintained between pulmonary endometriosis with distal parenchymal lesions and the less common endobronchial endometriosis. Only patients with the latter condition can take advantage of endoscopic laser therapy.

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