3. How much were the pressure limits adjusted?
4. How were the tidal volumes maintained at a constant flow during tracheal obstruction by the dilator?

In our study of 40 patients, the technique used ensured airway control with continuous pressure control ventilation, thanks to the gas supply at the carina level, so that it did not interfere with the surgical field and when the operating time was unexpectedly prolonged. Also, it allows the use of a normal flexible fiberoptic bronchoscope (Ø, 6 mm) for the whole procedure, without interfering with ventilation. The ventilation technique that we proposed seems to be secure independently from the percutane-ous procedure used in stabilized critically ill patients (mean ± SD) APACHE [acute physiology and chronic health evaluation] III score, 56.80 ± 24.03; PaO₂/fraction of inspired oxygen ratio, 253.41 ± 94.83), in whom even a short apnea time can be dangerous.

Fausto Ferraro, MD
Seconda Università degli Studi di Napoli
Naples, Italy

Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (www.chestjournal.org/misc/reprints.shtml).
Correspondence to: Fausto Ferraro, MD, Servizio di Terapia Intensiva, Seconda Università degli Studi di Napoli, Corso Vittorio Emanuele, 649/C, Napoli, Italy 80121; e-mail: fausto.ferraro@unina2.it

REFERENCES

Association Between Epidermal Growth Factor Receptor Mutation and Improved Survival in Never-Smokers With Primary Adenocarcinoma of the Lung

To the Editor:

In the August 2004 issue of CHEST, Nordquist and colleagues1 show that never-smokers with primary adenocarcinoma of lung are predominantly female, present at a higher mean age, and have improved survival when compared to current smokers. These findings may indicate that adenocarcinomas occurring in never-smokers may display a distinct natural history. Epidermal growth factor receptor (EGFR) protein overexpression was observed in 32 to 79% of cases of non-small cell lung cancer, and occurred more frequently in small cell lung cancer and bronchoalveolar carcinoma than adenocarcinoma or large cell carcinomas.2 Retrospective analysis of patients receiving single-agent ge-fitinib, a tyrosine kinase inhibitor that targets EGFR, showed that responses were more frequent among patients who had never smoked, women, and patients with bronchoalveolar carcinoma or adenocarcinoma with bronchoalveolar features as in the present study.3 It has been shown that these dramatic clinical responses in these patients are induced by activating mutations within the EGFR kinase domain,4,5 which stimulates antiapoptotic path-ways.6,7 In the light of above information and given the fact that chromosomal abnormalities are infrequent in never-smokers, mutations in the EGFR kinase domain may be one of the most important pathogenetic mechanism in this specific group of patients.

Ozden Altundag, MD
Kadri Altundag, MD
Hacettepe University Faculty of Medicine
Ankara, Turkey
Paolo Morandi, MD
S. Bartolo General Hospital
Vicenza, Italy
Mehmet Gunduz, MD, PhD
Okayama University
Okayama, Japan

REFERENCES

Sputum Eosinophils and Bronchodilator Reversibility

COPD or Asthma?

To the Editor:

The study by Perng et al1 evaluated the inflammatory cell constituent and bronchodilator reversibility of a group of patients...
(n = 88) with stable COPD. The authors concluded that eosinophils play a role in COPD and that along with assessment of bronchodilator reversibility, this knowledge can help tailor pharmacotherapy targeted toward the airways of such individuals.

Several points are worthy of mention regarding the selection of patients included in their study, all of whom had a significant smoking history. For example, the authors mentioned that part of their diagnostic criteria included the observation of symptoms of "progressive breathlessness, productive cough, and occasional wheezing." While undoubtedly these features are consistent with COPD, they are far from specific, and such symptoms are frequently found in asthma and other respiratory and nonrespiratory disorders.

Patients in the "bronchodilator reversible" group demonstrated mild airflow limitation with a mean FEV₁ of 54% predicted—consistent with either COPD or asthma. However, with a mean bronchodilator reversibility of 22%, it is pertinent to consider whether these were truly patients with COPD. Indeed, by definition airflow limitation tends to be fixed in COPD, rather than demonstrate significantly reversibility. Moreover, it is noted in the same group of patients that the median sputum eosinophil count was as high as 8%. It would also have been of interest if the authors had measured the gas transfer coefficient, which if impaired would have provided more convincing evidence of alveolar damage frequently found in COPD but not in asthma.

The results of the study therefore have to be taken lightly, in view of the highly questionable diagnosis of COPD. Moreover, if in fact the patients with significant reversibility and raised eosinophil count indeed had asthma—which may well have been the case (irrespective of smoking history)—it is certainly of grave concern that anti-inflammatory therapy with inhaled corticosteroids was not being instituted.

Graeme P. Currie, MD
Prasima Srivastava, MD
Aberdeen Royal Infirmary
Aberdeen, Scotland, UK
Daniel K. C. Lee, MD
Ipswich Hospital
Ipswich, UK

REFERENCES

The Intensivist Shortage
Put Patients Before Politics

To the Editor:

Emergency physicians are deeply concerned about the critical care crisis.1–3 Annually, 1.4 million patients are admitted to the ICU through emergency departments.4 Lack of ICU beds is the most common factor driving emergency department overcrowding and ambulance diversion.5

The authors of the recent CHEST series on this topic1–3 are so concerned that they want the federal government to relax its immigration laws so foreign medical graduates can be recruited into American critical care fellowships. Ironically, our country already has a potentially ample supply of qualified and interested candidates for critical care training: graduates of emergency medicine residency programs.

Unfortunately, only a minority of critical care fellowships accept emergency medicine residency graduates for training.6,7 Despite an intensivist shortage described as "dramatic, alarming, compelling, unprecedented and threatening,"1–3 the American Board of Internal Medicine proposes limiting access further by eliminating slots program directors previously could fill with non-internist medicine applicants. All this will do is create more unfilled slots.

The few emergency physicians who manage to complete a critical care fellowship are barred from taking a US certifying examination. This is the major reason why emergency medicine graduates do not seek formal training in critical care, according to an informal survey of the Emergency Medicine Residents’ Association estimated 5,000 members (C. Elie, MD: personal communication; May, 2004). The American Board of Medical Specialties has been asked to reconsider their position on numerous occasions, but has declined to do so.

Before asking Congress to change our immigration laws, shouldn’t the American Board of Internal Medicine and the American Board of Medical Specialties drop their opposition to critical care training and subsequent board certification for residency-trained emergency physicians? There is a nationwide shortage of properly trained intensivists that must be addressed. It is time to put patients before politics.

J. Brian Hancock, MD
Tiffany Medlin Osborn, MD
American College of Emergency Physicians
Dallas, TX

REMARKS