that the finding of significantly lower HPA-axis suppression as compared with HFA-BDP and CFC-BDP is useful information when assessing the therapeutic profiles of inhaled corticosteroids for use in the clinical setting.

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Noninvasive Ventilation and Dyspnea in Palliative Medicine

To the Editor:

We read with great interest the position paper of the American College of Chest Physicians about palliative and end-of-life care for patients with cardiopulmonary disease.1 We agree that it was about time for the "respiratory world" to write an official document on this hot topic. Having said that, we are concern that little emphasis was paid to the important problem of dyspnea and particularly on its treatment. Pain is one of the major fears of human beings, and every effort should be made to relieve this symptom. In the position paper,1 it is stated for example that "the factors most commonly associated with a request for physician-assisted suicide are patients' fear of losing control of mental faculties and experiencing severe pain". Pain is a classic symptom for example of patients with end-stage cancer. We are, however, pulmonologists dealing not only with cancer patients but also with the patients with end-stage COPD, in whom the "pain of the respiratory system" (ie, dyspnea) is the predominant symptom.

In the position paper,1 it was mentioned that the therapeutic options for dyspnea are oxygen, opioids, anxiolytics, and not-better-specified nonpharmaceutical interventions, basing this statement on a recent study published 4 years ago. In these last years, several studies were, however, published on the use of noninvasive ventilation (NIV) in patients with do-not-intubate order, with end-stage disease and severe dyspnea and/or respiratory distress. In the two more recent studies,2,3 it was demonstrated that about half of the patients survived the episode of respiratory distress and were discharged from the hospital. Indeed, in a pilot investigation2 it was showed that in a large portion of patients with end-stage solid cancer admitted to a palliative care unit for acute respiratory distress, NIV was able to significantly reduce dyspnea after only 1 hour of ventilation. A randomized international trial is in progress in 10 palliative care units in order to evaluate the effect of oxygen therapy alone or in combination with NIV, the main outcomes being the reduction in dyspnea and in the use of opioids. Again we congratulate the authors of the position statement for their efforts, but we also wish that the chest physicians will consider in future the possibility of using NIV in the palliative treatment of dyspnea as a peculiar and unique tool of the respiratory world.

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REFERENCES


2 Luce JM, Luce JA. Perspectives on care at the close of life: management of dyspnea in patients with far-advanced lung disease: “once I lose it, it’s kind hard to catch it.” JAMA 2001; 285:1331–1337

To the Editor:

We thank Dr. Nava for his comments regarding the recently published (November 2005) position paper of the American College of Chest Physicians on palliative and end-of-life care. Please understand that it was our intent not to be too prescriptive about specific therapies for the treatment of dyspnea; rather, we chose to emphasize the concept that such treatments need to be provided as appropriate to the individual patient. We agree that noninvasive positive-pressure ventilation (NPPV) has a role in decreasing dyspnea in selected patients, but it is not tolerated by all, often because of difficulty with the equipment interface. Nonetheless, it was our omission not to include NPPV as a nonpharmaceutical intervention that might be considered by the clinician.

You will be pleased to hear that the American College of Chest Physicians is in the planning stages of developing evidence-based guidelines on the treatment of dyspnea in advanced pulmonary and cardiac diseases. Along these lines, we welcome the results of your international trial in evaluating the effect of oxygen therapy with/without NPPV for the treatment of dyspnea.

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Reference