To the Editor:

The idea reported in the article by McCann et al (November 2005)1 that black patients decline surgical treatment for stage 1 and 2 cancers more frequently than their white counterparts requires careful scrutiny. This study should be assessed as an exploration of the ability of physicians to communicate their therapeutic objectives to black patients. Consequently, dynamic variables such as clarity of message, body language, and emphasis could not be captured by retrospective case record analysis. Furthermore, the authors neglected to evaluate the role of physician factors in their observations. This omission is surprising considering that many investigators have shown that physicians asymmetrically employ established standards when caring for black patients.2 McCann et al3 noted that all black patients who were offered surgery by black physicians accepted the procedure. However, this observation was not pursued further. Intriguingly, the authors also noted that elderly black patients declined surgery at an even greater frequency. It would have been interesting if the authors had explored whether this phenomenon correlated with the age, gender, or ethnicity of the advising physician. This line of thought would be in concordance with the notion that physician-patient differences are a causal factor in diverse cases of disparities in care.

The dynamic complexity of the sociocultural universe of modern metropolitan ethnic populations requires more complex communication skills than are required for situations in which the physician and patient are socioculturally more congruent. Uncovering the etiologies of racial disparities calls for innovative research in communication, including visual and audio record analysis as well as physician interviews, to explore the clinical logic behind discrepant care. These approaches would lead to practical solutions toward an important health-care delivery problem.

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To the Editor:

I thank Dr. Dube for his interesting comments about our article.1 He points out that a more complete evaluation of the physician-patient interactions would allow for a better understanding of why black patients declined surgical interventions for lung cancer. I agree with him. In the “Discussion” section of our article, we discussed the fact that prior research2 has shown that black patients seeing white physicians rated their physician’s decision-making style as less participatory. Since the publication of our article, research3 has shown that black patients with lung cancer have less trust in their physicians after the visit despite equivalent trust before the visit. As Dr. Dube points out, a better understanding of the dynamics of physician-patient communication and how they effect the development of trust will be a key factor in improving surgical rates.

Dr. Dube would have us further scrutinize physician demographic data to assess how it impacted decision making. As pointed out in the article,1 we only had three black patients offered surgery by black physicians. All three accepted. Given the small numbers, I am not sure how we could have pursued this further. He also wonders why we did not further evaluate the gender and age of the physician. We found no impact of patient gender on any of our outcomes, so we did not feel that physician gender would impact the offering or accepting of surgery. In terms of age, we did find that older patients were more likely to decline surgery. However, to evaluate the issue of concordance, we would want to ask the question of whether patients who met with physicians of similar age would be more likely to accept surgery. The average age of our patients was approximately 68 years. None of our physicians were >60 years old, and the majority were <40 years old. Thus, it would be hard to see how we could find concordance between patient age and physician age.

Our study was retrospective and meant to leverage the ability to review large numbers of cases to begin to evaluate the proximate causes of decreased surgical rates in black patients. We were thus unable to evaluate the physician patient interaction in depth. Nevertheless, we do feel that our research has provided the insight that we should focus efforts on physician-patient communication as a way to improve surgical rates in black patients with lung cancer. Such efforts would hopefully lead to increased surgical rates and thus decreased mortality from lung cancer in the African-American population.

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Severe Sepsis Due to Melioidosis

To the Editor:

We would like to comment on the retrospective review of melioidosis by Chan et al in a recent issue of CHEST (November 2005).1 We commend the authors on their work, which reinforces the high mortality rate associated with this infection, particularly in those patients with a critical illness.

Contrary to their assertion that melioidosis in the ICU setting has not previously been described, we have previously published2 our experience of 42 critically unwell patients with culture-confirmed melioidosis. In our series, we noted a fall in the mortality rate from 95% to 9.5% coincident with the introduction of granulocyte colony-stimulating factor (G-CSF) in patients with septic shock. We also acknowledged that the large fall in the mortality rate that we observed may have been at least partly explained by other potential confounders, including the adoption of a closed intensive care model, the earlier use of antibiotics active against Burkholderia pseudomallei, and more aggressive fluid resuscitation. We have also demonstrated that pneumonia and biochemical markers of organ dysfunction are generally associated with mortality in patients with melioidosis.3

Studies of melioidosis have been difficult to compare due to the large clinical spectrum of illness and variations in the definitions of “severe melioidosis.” This is reflected in the differences in the rates of bacteremia between studies. However, severe sepsis (as defined by Chan et al1) and septic shock (as defined in our series) represent the group with the highest mortality rate due to melioidosis. The mortality rate that we observed in patients who received G-CSF in our series was lower than that observed by Chan et al1 in a population with a similar severity of illness. Chan et al1 did not differentiate pneumonia with septic shock from pneumonia without septic shock; the Darwin experience suggests that pneumonia with septic shock is associated with an 84% mortality rate.4

We suggest that the measures associated with the fall in mortality at our institution, namely, the use of G-CSF, the routine use of empiric antibiotics for melioidosis, and the use of aggressive fluid resuscitation, should be considered for patients with severe sepsis in melioidosis-endemic areas. We have participated in studies aimed at identifying patients with melioidosis by the use of clinical criteria and rapid diagnostics,5 and we are in the process of conducting a clinical trial of G-CSF for the treatment of severe melioidosis in Thailand.

The authors have reported to the ACCP that no significant conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (www.chestjournal.org/misc/reprints.shtml).

REFERENCES


Left Ventricular Diastolic Abnormalities in Obese Subjects

To the Editor:

The study by El-Ganaal et al (December 2005) presented evidence of an association between the degree of dyspnea and both an increased ventilatory drive and reduced static lung volumes. Indeed, weight loss was accompanied by improvement in dyspnea and a reduction in respiratory drive measurements. We would like to comment on one other possible mechanism that was not addressed by the authors explaining the frequent presence of dyspnea in obese patients and the improvement in the degree of such symptoms after weight loss. Left ventricular diastolic dysfunction is a frequent cause of dyspnea. It is commonly present in obese subjects and is correlated with increasing body mass index. In obese subjects, weight loss produces an improvement in left ventricular diastolic function that is linked to weight loss-related decreases in left ventricular mass and beneficial alterations in left ventricular loading conditions. On the other hand, the authors did not perform polysomnography to rule out obstructive sleep apnea or other sleep disorders, as they acknowledge in the “Discussion” section of their article. It is well-recognized that the vast majority of sleep apnea patients are undiagnosed, and that obstructive sleep apnea is a very common condition affecting obese subjects. This sleep-related disordered breathing has also been independently associated with left ventricular diastolic dysfunction and reduced cardiac response to exercise. Weight loss in obese obstructive sleep apnea patients is coupled with an improvement in sleep disorder severity, and the reduction of apneic events has also been associated with subse-