Response

To the Editor:

We appreciate the interest of Paone et al in our recent article in CHEST (May 2008), which aimed to describe the clinical course and outcome of patients with interstitial lung disease and acute respiratory failure in relation to ventilatory parameters. The inhospital mortality after acute respiratory worsening in patients with idiopathic pulmonary fibrosis (IPF) requiring mechanical ventilation in our study was high (60%), but not as high as in the study by Mollica et al (85%). As pointed out, the difference is likely the result of systematic methodological differences (i.e., higher number of postoperative respiratory failures, different patient inclusion criteria and study definitions).

The baseline severity of illness is the most important outcome determinant. Despite the poor hospital survival, some patients with IPF, especially postsurgical patients undergoing mechanical ventilation, can survive an acute exacerbation—thus the importance of identifying a treatable cause for the exacerbation.

Patients with IPF are clearly at increased risk for ventilator-induced lung injury. Our findings suggest that patients with fibrotic lung disease and especially those with advanced IPF may be harmed by lung recruitment maneuvers and high positive end-expiratory pressure commonly used to improve oxygenation. The determination of which patients are most likely to benefit from mechanical ventilation, as well as the optimal ventilatory strategy, awaits further investigation.

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REFERENCES


Accuracy in Identifying Podiatric Surgeries

To the Editor:

We read with interest the recently published article in CHEST (April 2009) by Felcher et al. Although they should be commended for bringing emphasis to venous thromboembolic (VTE) disease as a postsurgical complication of foot surgery, we found a few areas of concern in their manuscript.

We noticed from Table 2 that nearly half of the outpatient procedures were either “foot injections” or “drainage of a joint/bursa/cyst.” These procedures have a low pretest probability of VTE and are generally not considered hazardous enough to warrant deep venous thrombosis (DVT) prophylaxis. Therefore, inclusion of these procedures biases the outcome toward a reduced risk. The other procedures listed are, for the most part, foot surgeries.

The purpose of the title of a medical journal article is to catch the attention of the readership and to provide a tag for search engines. Thus, the title should accurately represent the contents and conclusions of the article. We find the title of this article misleading for two reasons. First, the title implies that injections and aspirations are classified as surgeries. Second, when describing the “surgeries” performed, the authors use the term “podiatric,” which refers to a degree and not specifically an anatomical region. Their study did not include all the surgeries typically performed by surgeons with this degree. It appears that this study was limited to simple foot surgeries, and from what we can discern there were no ankle or leg surgeries. Thus, since the procedures studied did not include the full breadth of what the average podiatrist performs, it would be a mischaracterization to state that “the incidence of VTE is low for podiatric surgeries.” It is also confusing that the authors state that “only one study calculated VTE incidence rates in podiatric surgery”, but then subsequently cite six other studies regarding foot and ankle surgery that evaluate VTE, as if podiatric foot and ankle surgery were different from orthopedic foot and ankle surgery.

It is difficult for us to perform calculations on the data that were provided in this study since procedures and patients are reported separately, and some patients had more than one procedure. However, if we make the assumption that none of the VTEs occurred in the injection/aspiration subjects and remove them from the sample number, the rate of VTE could increase to near 0.53%, which is not a small amount in regard to a clinically significant post-procedural sequela.

Although we would agree that a thorough review of the available medical literature would lead one to conclude that routine prophylaxis against VTE in foot and ankle surgery is not warranted, individual consideration should be given on a case-by-case basis. Although the authors acknowledge that they did not capture data on immobilization, probably the biggest risk factor for DVT, most of these foot surgeries would not require prolonged immobilization or non-weightbearing. The authors do note a few risk factors for development of VTE, including
by the same token, we chose not to exclude any of the procedures done in a typical podiatrist’s practice, including injections and percutaneous drainages. While a proportion of the 16,804 surgical procedures identified in our study involved foot injections (Current Procedural Terminology [CPT] 20550) or drainage of a joint/bursa/cyst (CPT 20605 and 20600), incidence rates are computed at the patient level (n = 7,264 in our full study population), thus many patients had multiple procedures that included both these and more extensive surgeries. In performing a sensitivity analysis adjusting for injection/drainage procedures, we find three patients with symptomatic postprocedure VTE who received both these procedures and more invasive surgeries. Adjusting our sample to include only those who had a more invasive procedure, we find the pool reduced to 5,621 individuals, and we continue to compute low adjusted incidence rates of VTE at 0.39% overall (0.21% for deep vein thrombosis only; 0.18% for pulmonary embolism only). Incidence rates remain in the low risk strata, and our conclusion that VTE prophylaxis is not indicated for routine podiatric procedures in patients without any additional risk factors for VTE remains valid, even after adjusting for injections/drainage. As we note in our paper, definitive decisions about VTE prophylaxis should be made on an individual patient basis; in this we agree with Drs Budny and Rogers.

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References

Response

To the Editor:

We appreciate the opportunity to respond to Drs Budny and Rogers’ comments on our recent article in CHEST (April 2009).1 Although we agree that podiatrists and orthopedists may perform the same foot and ankle procedures, our intent was to describe the risk of venous thromboembolism (VTE) in patients under the care of a typical podiatrist doing common podiatric procedures in a common podiatric practice. Our database included more than 16,000 procedures done by all of the podiatrists in a large medical group over 5 years and reflects the variety of procedures performed by the vast majority of podiatrists, hence the title of our article. We did not exclude any particular foot or ankle surgeries; thus, the forefoot proportion is representative of the practice in podiatrists. Likewise, the podiatric distinction clarifies the confusion regarding incidence computation in the studies referenced in our article. Only one study estimated the incidence of VTE seen by podiatrists, whereas six studies explored VTE in foot/ankle surgery performed by orthopedists.2 Although we agree there is merit in either approaching VTE risk by surgical specialty experience or by specific procedures or anatomic regions, we chose to elucidate risk in a large general podiatrist practice.

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