that study, the addition of the ICU admission source and intensity of treatment improved the mortality prediction, leading us to include them in our recent study in CHEST. Because of the collinearity concern raised in the letter, we performed a multiple logistic regression analysis without including the intensity of treatment and the source of admission as predictor variables. The observed association between admission during rounding time and risk of death remained significant, with an odds ratio (95% CI) of 1.644 (range, 1.466-1.842) and P < .001.

We agree with Drs Desai and El Solh that the use of multiple logistic regression analysis does not compensate for the lack of randomization. Although propensity score may have partly reduced the bias in our study, it would not have solved the limitations imposed by the lack of randomization. Propensity score analysis does not balance unobserved covariates, and although intuitively appealing, there are unanswered questions related to its advantage over the conventional logistic regression analysis in estimating unbiased treatment effects.

We agree with Drs Desai and El Solh that the nurse-to-patient ratio and variations of other support staff may have impacts on the outcome of the critically ill. Our ICU nurse-to-patient ratio is not affected by round time and remains the same at all times. The same applies to respiratory therapists, who are present in the ICU at all times. Pharmacists are present in the ICU between 7:00 AM and 11:00 PM and in the hospital at all times. Therefore, we do not think the overall nonphysician staffing by itself is likely to explain the observed association between admission during ICU rounds and mortality in our study.

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Propofol and Fospropofol Sedation During Bronchoscopy

To the Editor:

We read with interest the excellent editorial by Michael Jantz (January 2009) that nicely summarized the existing data on the safety of propofol for pulmonary endoscopy. We would like to add that propofol also has an excellent record of safety for GI endoscopy.

A recently published study documented the safety of propofol-assisted sedation in >500,000 patients undergoing various GI endoscopies. When using propofol sedation, we basically need to follow the same precautions as when using any other drugs for analgesic-sedation, such as benzodiazepines and opioids. This means that the physician and nurse performing the endoscopy should properly select the patient, adequately monitor the patient during the procedure, and be qualified to rescue patients whose levels of sedation become deeper than initially intended. The physician should be educated and trained in the pharmacology of sedative drugs used, airway management, and advanced life support. An advantage of pulmonary endoscopists over GI endoscopists, though, is their familiarity with the upper airways, potentially enabling a more efficient and smooth endotracheal intubation in an emergency situation. In addition, if an intubation should become difficult, the bronchoscope itself also could be used as a guiding instrument to advance the endotracheal tube and achieve proper tracheal intubation.

To finish, we disagree with Jantz regarding the classification of propofol. Jantz asked us to keep in mind “that fospropofol is a different drug than propofol and that fospropofol is not a general anesthetic.” Indeed, propofol is not classified as an anesthetic either. Propofol (2,6 diisoproplyphenol) is an ultra-short-acting sedative-hypnotic agent with amnesic but no analgesic properties. Originally, it was mainly used for the induction of general anesthesia, but currently, it is widely used for sedation of patients on mechanical ventilation and various types of endoscopic procedures. Thus, we conclude that based on the available data, propofol (and not only fospropofol) appears safe for mild-to-moderate sedation in gastrointestinal and pulmonary endoscopy.

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