a starting point from which to evaluate claims and requests from patients and surrogates alike.

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REFERENCES

Could Decortication Become Necessary in Cases of Pseudochylothorax?

To the Editor:

We read the article by Wrightson et al. (October 2009)1 with great interest. Pseudochylothorax is still an interesting entity in thoracic surgery because of its rarity and the uncertainty of its etiopathogenesis.2,3 In this article, Wrightson et al.4 described the role of videothoracoscopy in checking the thickness of the pleura in patients with a known diagnosis resulting from pseudochylothorax. We suggest that videothoracoscopy is not necessary in this group of patients.

We previously performed thoracentesis to diagnose pseudochylothorax in five patients and performed underwater chest tube drainage. Pleural biopsy was performed in one patient who was admitted with no primary disease resulting from pseudochylothorax. Mean initial drainage was 1,100 mL/s. All patients recovered with conservative treatment, except one in whom pulmonary expansion could not be achieved, so that thoracotomy and decortication were necessary. These procedures were difficult and incomplete because of severe inflammation and thickening of the pleura. Multiple incisions were made over the pleura to expand the lobes.

In our experience, the pleura in patients with pseudochylothorax can either be thin or thick. These possibilities should be kept in mind when decortication becomes necessary. Also, we believe videothoracoscopy is not necessary in patients with known primary disease. We thank Wrightson and colleagues for sharing their experience and cases in their practices and providing an opportunity for us to discuss this rare entity.

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REFERENCES


Response

To the Editor:

We thank Drs Cansever and Bedirhan for their suggestion that video-assisted thoracoscopic surgery (VATS) is not necessary for patients with pseudochylothorax. Our case series discussed six patients with arthritis-associated pseudochylothorax who were particularly notable because of their minimal pleural thickening. These findings were in striking contrast to the previously held belief that gross pleural thickening is a prerequisite for pseudochyle formation.5

Of the six patients discussed, three had a thoracoscopy primarily to obtain biopsy specimens for exclusion of TB and malignancy. It is worth highlighting that physicians performed the pleuroscopies (local anesthetic thoracoscopies) under conscious sedation. None of our patients had general anesthetic VATS, and a decortication was not required (given the minimal pleural thickening).

We entirely agree that neither pleuroscopy nor VATS is necessarily mandated for diagnostic purposes in patients with unequivocal pseudochylothorax with a clear etiology, such as rheumatoid arthritis. Unfortunately, the clinical scenario frequently is not so clear cut particularly because TB causes the majority (54%) of pseudochylothoraces worldwide.2 Physicians therefore should always consider alternative diagnoses, such as TB, particularly in patients who are relatively immunosuppressed due to treatment of rheumatoid arthritis. Where there is any diagnostic doubt, an outpatient pleuroscopy is a one-stop procedure to obtain pleural biopsy specimens and achieve pleural volume control. However, one particular question remains: How often do pleural biopsy specimens add diagnostically useful information in cases with grossly thickened pleura vs those with relatively normal pleura? It is conceivable that biopsy specimens from intensely thickened pleura are less likely to be helpful, potentially yielding fibrous tissue rather than findings characteristic of a specific underlying disease.

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Less-Obvious Predictors of Post-ICU Informal Caregiver Burden

To the Editor:

In a recent issue of CHEST (January 2010), Van Pelt and colleagues showed how predictors of caregiver burden vary over time. As their study emphasized the need to broaden the focus of patient- and caregiver-specific interventions, we have suggestions that can help to direct future research in this area.

The hospital admission of a seriously ill family member often imposes a substantial financial burden on the family, and this contributes to the overall burden on the caregiver. In a multicentric study comprising 2,123 admissions, the patients' critical illness meant the loss of a major source of their family's income for 29% of the caregivers. Hence, although the level of patient dependency on caregivers did not affect caregiver outcomes in the study by Van Pelt and colleagues, any data (either in this or future studies) on how many patients significantly contributed to the family income prior to admission and whether the number of patients returning to work varied over the time can reveal how the change in the financial situation influences the caregiver burden.

The authors also suggested that caregiver burden may be affected by less-obvious factors like the caregiver's perception of the patient's suffering. We have earlier highlighted the concept of "inappropriate worry." We correlated worry among caregivers 48 to 72 h after patient admission with their perception of change in the patients' critical state and found a clear discrepancy. Out of 76 family members, only 50% experienced worry that was in keeping with the change in the patients' condition. In the remaining 50%, the worry was incongruous. We also found that in more than one-half the cases, there was a discrepancy between the objective change in the patients' acute status (measured as the change in the Acute Physiology and Chronic Health Evaluation II score since admission) and the caregivers' perception of the change (subjective change) in the patients' critical state. Although our study was cross-sectional, the long-term effects of this discrepancy, as well as whether mitigating this discrepancy relieves caregiver burden, remain to be explored.

Final disclosure: The authors have reported in an earlier study that up to 14% of caregivers stopped working in order to provide care for their loved ones. The authors also suggested that caregiver burden may be affected by less-obvious factors like the caregiver's perception of the patient's suffering. We have earlier highlighted the concept of "inappropriate worry." We correlated worry among caregivers 48 to 72 h after patient admission with their perception of change in the patients' critical state and found a clear discrepancy. Out of 76 family members, only 50% experienced worry that was in keeping with the change in the patients' condition. In the remaining 50%, the worry was incongruous. We also found that in more than one-half the cases, there was a discrepancy between the objective change in the patients' acute status (measured as the change in the Acute Physiology and Chronic Health Evaluation II score since admission) and the caregivers' perception of the change (subjective change) in the patients' critical state. Although our study was cross-sectional, the long-term effects of this discrepancy, as well as whether mitigating this discrepancy relieves caregiver burden, remain to be explored. Finally, discerning whether satisfying relevant caregiver needs during a patient's hospital course and follow-up has a long-term effect on the caregiver is another area that could help to identify targets to reduce caregiver burden.

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REFERENCES


