to understand the inner state of the patient, including the internal and external influences that impede autonomous choice, rather than simply assuming that statements of choice can be accepted at face value. Clinicians should feel comfortable making best-interest assessments regarding the care of their patients and should make those assessments explicit when necessary. The choices of non-autonomous individuals are not to be respected when one knows that harm will follow. To say that the principle of autonomy rests on the ability of the individual to make autonomous decisions is not a tautology; if a patient is unable to make autonomous decisions, the clinician who relies on the articulated choices of such a patient to determine the course of care will be making a clinical and a moral error.

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Complications of Talc Poudrage in the United States

To the Editor:

A recent article in CHEST (June 2010) by Gonzalez et al 1 on the complications of talc pleurodesis is important because it may be the largest report on the use of Sclerosol talc (Bryan Corporation; Woburn, Massachusetts), the only proprietary talc sanctioned by the US Food and Drug Administration (FDA). The article would have been enhanced if the authors had shared their 1- to 6-month success rates for pleurodesis, because Sclerosol may be more or less effective than other talcs. Conversations with Bryan Corporation representatives suggest that the current talc is different from the original one.

One of their goals (to define the incidence of lung injury from talc) cannot be met in this kind of retrospective study because a pathognomonic finding for talc lung injury has not been defined. Their estimate of a 2.8% incidence is subjective, which they acknowledge (referred to as “consensus” in their article). Radiographic findings may be seen after pleural drainage or thoracoscopy without talc insufflation.

Two articles were inappropriately referenced as showing complications of talc insufflation. Rehse et al 2 found zero cases of respiratory failure after simple talc poudrage but several cases of ARDS when talc was applied following pleural abrasion, a procedure that disrupts blood vessels, allowing access of talc to the circulation. Dressler et al 3 in comparing bedside talc slurry per chest tube with video-assisted thoracic surgery/talc poudrage, inappropriately implicated talc insufflation in the complication rate. The patients who underwent video-assisted thoracic surgery had six complications of bronchopleural fistula, indicating that the patients had surgical procedures, not simple talc insufflation; bronchopleural fistula is not a complication of medical thoracoscopic talc insufflation.

There are many US Pharmacopeia talcs available in the United States. We reported 286 consecutive thoracoscopic talc poudrages using talc from Spectrum Chemical Co (Gardena, California), without any pulmonary infiltrates ascribed to talc when given in 5-g doses. Unfortunately, the FDA recently ruled arbitrarily that US Pharmacopeia talc must be sterilized under the supervision of a pharmacist, even though other thoracoscopic materials are sterilized by the hospital’s central supply. Many pharmacies are not equipped for the sterilization procedure. Our team switched to Sclerosol in 2004, which raised the talc cost per patient from 15 cents to $2.40. Our success rate of 90% at 1 year with the Spectrum talc 4 dropped to 13/18 (72%) (Y. Aelony, MD, unpublished data, 2002, 2004), stressing the importance of the unknown success rate in the article by Gonzalez et al. 1 I second Gonzalez’ call for the FDA to approve the European-graded (large-particle) talc because it has been shown prospectively not to cause ARDS in 553 cases, 5 and it has a long-term effectiveness of about 90% in thousands of cases.

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