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.

Mark R. Tonelli, MD, FCCP
Seattle, WA
Cheryl J. Misak, DPhil
Toronto, ON, Canada

Affiliations: From the University of Washington (Dr Tonelli); and the University of Toronto (Dr Misak).

Financial/nonfinancial disclosures: The authors have reported to CHEST that no potential conflicts of interest exist with any companies/or organzations whose products or services may be discussed in this article.

Correspondence to: Mark R. Tonelli, MD, FCCP, Box 356522, 1959 NE Pacific St, Seattle, WA 98195-6522; e-mail: tonellir@uw.edu

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DOI: 10.1378/chest.10-2485

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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. on the complications of talc pleurodesis is important because it may be the largest report on the use of Sclerosol tale (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 tales. Conversations with Bryan Corporation representatives suggest that the current tale is different from the original one.

One of their goals (to define the incidence of lung injury from tale) cannot be met in this kind of retrospective study because a pathognomonic finding for tale 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 tale insufflation.

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

There are many US Pharmcopia tales available in the United States. We reported 286 consecutive thoracoscopic tale poudrages using tale from Spectrum Chemical Co (Gardena, California), without any pulmonary infiltrates ascribed to tale when given in 5-g doses. Unfortunately, the FDA recently ruled arbitrarily that US Pharmcopia tale 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 tale cost per patient from 15 cents to $240. Our success rate of 90% at 1 year with the Spectrum tale 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. I second Gonzalez’ call for the FDA to approve the European-graded (large-particle) tale because it has been shown prospectively not to cause ARDS in 535 cases, and it has a long-term effectiveness of about 90% in thousands of cases.

Yossef Aelony, MD, FCCP
Harbor City, CA

Affiliations: From the Southern California Permanente Medical Group.

Financial/nonfinancial disclosures: The author has reported to CHEST that no potential conflicts of interest exist with any companies/or organzations whose products or services may be discussed in this article.

Correspondence to: Yossef Aelony, MD, FCCP, Southern California Permanente Medical Group, Kaiser-Permanente Lakeside Bldg, Medicine III, 29225 Vermont Ave S, Harbor City, CA 90710; e-mail: yaelony@cox.net

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DOI: 10.1378/chest.10-2267

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