shown to be of no value—or even harmful—include avoidance of β-blockers in heart failure treatment, insulin for schizophrenia, vitamin K for myocardial infarction, hormone replacement therapy to prevent cardiovascular disease, flecainide for ventricular tachycardia, and immobilization of scaphoid bone fractures. Many other examples could be mentioned.

Dr MacLaren cites the good outcome of his four patients with 2009 influenza A(H1N1), whom he supported with ECMO. One must be careful, we believe, to separate proper decision making from patient outcome. Because of the probabilistic nature of the link between decisions and outcomes, it is clear that good decisions can be followed by bad outcomes, and bad decisions followed by good outcomes.

We agree with Dr MacLaren that ECMO is easier to apply now than in the past. The ease of application, however, does not replace the need to know when, how, and in whom we can optimally use it. The ease of application, however, does not replace the need to know when, how, and in whom we can optimally use the technique. Citing the need for a multidisciplinary and expert team does little to answer this need.

We agree with Dr MacLaren that there exist “practical difficulties of conducting” randomized clinical trials. We believe that it is even more difficult to draw compelling conclusions from uncontrolled clinical experience. We recognize that this depends on the signal-to-noise ratio. It is possible that a large observed change in clinical outcome (eg, the response of pneumococcal pneumonia to penicillin in the 1940s) could produce compelling data, but this has not been the case with ECMO in adults with respiratory failure. Finally, the following quote seems appropriate: “To safeguard against ineffective or harmful health care we need clinicians who want to do the best they can for their patients, who are willing to continually question their own managements, and who have readily available sources of information about what does work.”

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Fluorodeoxyglucose-PET Scanning in the Diagnosis of Pleural Disease

To the Editor:

I thank Battah et al1 for sharing an interesting case and uncommon presentation of ankylosing spondylitis in a recent issue of CHEST (October 2010). Clarification of the authors’ conclusions, however, is required regarding their assertion that fluorodeoxyglucose (FDG)-PET scans showing increased uptake in pleural disease may be reassuring, as stated in the “Clinical Pearls” section of the article.

FDG-PET scanning has been well integrated into the workup for the evaluation of the indeterminate, solitary pulmonary nodule;2,3 however, its use in guiding further testing in pleural disease remains less well defined. The general consensus for solitary pulmonary nodule management is that increased FDG uptake should guide the clinician toward a more invasive approach rather than watchful waiting in the case of an unclear clinical diagnosis. Although this guideline cannot be extrapolated to pleural-based diseases, there is increasing evidence to suggest that augmenting clinical data with FDG-PET scanning may be useful in pleural disease management.4,6

Battah et al1 mention “the appropriate clinical setting” as a scenario in which increasing FDG uptake is reassuring enough to defer biopsy, but only a low-probability patient would meet this requirement (not necessarily this patient who was a smoker and construction worker), and even then, an increase in FDG-PET scanning may bias the clinician toward biopsy. In the absence of necessary studies to synthesize data and investigate this topic in more detail, clinicians should be aware that increasing FDG uptake in diagnostic dilemmas of the pleura is worrisome and may require further investigations, perhaps invasive, if necessary.

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Response

To the Editor:

We thank Dr Nair for his pertinent comments concerning the use of fluorodeoxyglucose (FDG)-PET scanning in the evaluation of pleural disease. As we made clear in our description of a case of pleural disease associated with ankylosing spondylitis (AS) recently published in CHEST (October 2010), 1 FDG-PET scan-avid pleural lesions only denote increased metabolic activity within the area of interest but do not provide specific information concerning the source of that activity, which may be neoplastic or inflammatory. 2 As is true for many imaging modalities, on some occasions the clinical scenario and/or radiographic appearance are such that a specific nonmalignant diagnosis can be made with enough confidence to obviate the need for an invasive procedure. Clearly, in our patient with a history of tobacco use and possible asbestos exposure it was mandatory that a firm, histologic diagnosis be pursued.

Nevertheless, we believe it is important to remind clinicians that FDG-PET scan avidity has been demonstrated in a wide variety of inflammatory disorders affecting the lungs and pleura, including infection as well as noninfectious granulomatous disease, such as those produced by talar pleuritis or due to sarcoidosis. 3-6 However, the appearance of pleural disease associated with collagen vascular disorders on FDG-PET scan has only rarely been reported. Rheumatoid arthritis with FDG-PET scan-avid pleural involvement has been described in only one previous report. 7 Spinal lesions with FDG-PET scan avidity are known to occur in patients with AS, 8 but it appears that our case is the first to describe FDG-PET scan positivity in pleural disease due to AS.

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Silicosis: Hidden Behind TB?

To the Editor:

We read with great interest the case report of a 53-year-old man with dysphagia, anorexia, and night sweats by Ferguson and Schwarz in a recent issue of CHEST (November 2010). 1 We believe a few issues need to be addressed after going through this report.

Although a diagnosis of TB was confirmed on sputum cultures, coexistence of a concomitant pneumococosis (eg, silicosis in this case) cannot be ruled out because there is a history of exposure to the cement industry. Silicotuberculosis is a well-described entity in literature, and it is said that silicosis increases the predisposition toward TB. 2 The parenchymal nodules on chest radiograph and diffuse miliary pattern with mediastinal lymphadenopathy on CT scan described in this patient can be associated with silicosis. 3 In this patient, the miliary shadows could be present because of preexisting silicosis and right upper lobe infiltrate because of superadded TB infection. Flexible bronchoscopy (transbronchial lung biopsy and BAL) or, preferably, open lung biopsy might have

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