Benefit or Burden?

Sending Patients With Nonresectable Lung Cancer to the ICU

To the Editor:

In a recent issue of CHEST (January 2011), Toffart and colleagues reported the results of a retrospective study of patients with lung cancer admitted to ICUs at three tertiary care centers in France. The aim was to evaluate whether ICU admission improved 3-month survival rates in patients with nonresectable lung cancer. At 90 days, 63% of the patients had died; the authors concluded that although the overall survival rate was low, ICU care provided some patients with meaningful benefits—most prominently, increased time at home for those who survived to discharge. The authors also found that physiologic deterioration within 72 h of ICU admission (as measured by the logistic organ dysfunction score) was associated with worsened survival and suggested that such deterioration could identify patients for whom ICU care might be withdrawn.

We applaud the authors for reporting outcomes, especially those beyond hospitalization, among a group of patients often considered to have a dismal survival rate. Undoubtedly, survival is improved for nearly all critically ill patients transferred to the ICU who would otherwise succumb to organ failure; indeed, a randomized controlled trial to test this hypothesis would be unethical. However, beyond this broad stroke, we suggest that a more detailed quantification of improved survival depends on identifying a relevant comparator group. In this study, for example, an appropriate group might have been ICU patients without lung cancer who had similar reasons for admission and measures of cause-independent organ dysfunction—perhaps matched by logistic organ dysfunction scores. In this context, the independent effect of lung cancer on ICU patients’ survival might be more clearly defined.

As the authors themselves state, ICU care is burdensome. Thus, decisions about whether such care is justifiable depend on defining the potential benefits of ICU admission so that they can be balanced against its burdens. Ideally, armed with this knowledge, clinicians, patients, and families will be able to make plans at the most appropriate time: before such burdensome care is imposed.

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REFERENCES

Combined Imaging for Benign Mediastinal Lymphadenopathy

Endoscopic Ultrasonography First or Endobronchial Ultrasonography First?

To the Editor:

I read with interest in a recent issue of CHEST (November 2010) the correspondence by Drs Medford and Agrawal about the use of combined endoscopic ultrasound-guided fine needle aspiration (EUS-FNA) and endobronchial ultrasound-guided fine needle aspiration (EBUS-FNA) in the diagnostic evaluation of benign diseases, such as TB, by an endobronchial ultrasound (EBUS) scope. In their correspondence, the authors discussed the feasibilities of combining the imaging modalities to perform fine needle aspiration (FNA) initially from the respiratory tract (EBUS-FNA) and, then, using the same scope, from the esophagus (EBUS-transeosophageal-FNA). The combined approach has potential advantages because it reduces the need for an additional instrument, the operating costs, and the duration of the procedure.

My colleagues and I have defined the standard stations and imaging techniques for fine needle aspiration (FNA) cytology of lymph nodes by endoscopic ultrasound (EUS) from the esophagus and by EBUS from the respiratory tract. We do not favor the use of EBUS-transeosophageal-FNA because the EBUS scope has a limited vision and depth of penetration. Further, it provides a poor-quality ultrasound image because of its limited range of scanning (50°-70° by EBUS scope vs 120°-180° by EUS scope). The availability of an elevator in the EUS scope makes FNA more convenient and enables axis change during multiple passes. Although these experts were able to perform EBUS-transeosophageal-FNA, it could be difficult for the newer generation of interventional bronchoscopists to acquire this expertise.

When evaluating benign mediastinal lymphadenopathy (BML), a diagnosis can be made through ultrasound-guided procedures like EBUS and EUS. It could be difficult to select the order of preference if both the techniques are available to the bronchoscopist because no suitable comparison of the results is available in the literature. Once a suitable comparison is made by studies, then only an order of diagnostic FNA (transeosophageal first or transbronchial first) can be finalized. The new generation of bronchoscopists needs clear-cut algorithms. Until the algorithms are available, EUS-FNA could be considered the first test for ultrasound-guided evaluation of BML because of the ease and safety of the procedure. The role of EBUS-FNA for BML could...