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with worsened survival and suggested that such deterioration could identify patients for whom ICU care might be withdrawn.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.1,2 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.3,4 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
be debatable if standard EUS-FNA is easily available. Whatever the order of imaging, the bronchoscopist needs two scopes and must learn the techniques of doing EUS with an EUS scope and EBUS with an EBUS scope. Even if end results are satisfactory, the means may not be justified.

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

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DOI: 10.1378/chest.11-0455

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Response

To the Editor:

We note the comments of Dr Sharma in response to our initial publication1 on using 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, EBUS-transbronchial needle aspiration (EBUS-TBNA), and endoscopic ultrasound bronchoscope-guided needle aspiration (EUS-B-FNA). To clarify the purpose of our observations, we were seeking to highlight the potential usefulness of EUS-B-FNA for those practitioners trained in this application, particularly in situations where EBUS-TBNA was not tolerated as well for reasons of refractory cough, poor lung function, or significant comorbid lung disease. In these situations, in particular for an enlarged subcarinal node or paraesophageal lesion, we would use EUS-B-FNA to sample the lesion at the same sitting, with the same equipment, to avoid a nondiagnostic procedure.

Our center currently does not have ready access to an endoscopic ultrasound (EUS) scope. If an EUS scope were available, however, we concur that this would allow greater access and scanning range for a complete EUS procedure, but that was not the purpose of our observation. We are not advocating EUS-B-FNA as a replacement or substitute for complete EUS-FNA, which requires training with an EUS scope, as the authors have stated. We also agree with the authors that EUS-B-FNA should not be performed unless the operator is trained in this particular application of the EBUS scope.

We do not agree that EUS should be the first investigation for suspected benign lymphadenopathy in all situations; EBUS-TBNA is also a safe and technically straightforward procedure (as is EUS-FNA), although cough (which is not encountered with EUS) may be an issue. In our opinion, the first minimally invasive needle aspiration procedure should be guided by the location and accessibility of the lymphadenopathy, which may mean EUS-FNA for some locations or EBUS-TBNA for others.

There are many centers that might have EBUS or EUS but not both modalities available, limited by the costs of these techniques. We suggest, therefore, that the available technique in the institution might also dictate which is the first-line investigation. If both are available, then, as discussed, anatomic factors should be considered. However, there is no evidence in the literature to clarify this choice, and, thus, we also agree that comparative studies are required.

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

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DOI: 10.1378/chest.11-0541

References


Rapid On-site Evaluation of Transbronchial Aspirates in Mediastinal Adenopathy Diagnosis

To the Editor:

The results of the randomized trial by Trisolini et al1 in a recent issue of CHEST (February 2011) are noted with interest. It is