alveolitis with 22% lymphocytes and 10% neutrophils. Transbronchial biopsies were not performed because of poor tolerance for BAL. Prednisone was given at 80 mg/d (1 mg/kg) with little response in terms of muscle weakness and no respiratory improvement after 15 days. A bolus of 0.6 mg/kg of cyclophosphamide was administered, as currently recommended for refractory cases.² Reassessment before the second scheduled cyclophosphamide infusion revealed a dramatic deterioration of pulmonary function (TLC, 41%; VC, 51%; and DLCO, 32%). Cyclophosphamide treatment was stopped, and IV Ig at a dosage of 2 mg/kg was begun.

A marked clinical and biologic improvement (normalization of creatine kinase) was observed 21 days after the first infusion. After three monthly courses of IV Ig, the patient recovered normal muscle function and showed a marked improvement on pulmonary function test (TLC, 59%; VC, 63%; and DLCO, 51%) and a regression of fibrotic changes on CT scans. This observation lends support to the suggestion that IV Ig treatment might be considered as a treatment of ILD-PM/DM, especially for critical cases.

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References


Transtracheal Oxygen Therapy Success

To the Editor:

I am writing in regard to the article by Christopher and Schwartz on transtracheal oxygen therapy (TTO) in a recent issue of CHEST (February 2011). Long-term oxygen therapy (LTOT) by the transtracheal route has not been given enough credit by the medical community. I speak from experience as a retired board-certified general surgeon with severe COPD who is receiving LTOT.

I required nocturnal oxygen using a nasal cannula for 8 years but suffered with recurrent epistaxis due to the nasal cannula. One year ago, after an acute exacerbation, I required continuous oxygen, and this presented a dilemma due to the ongoing epistaxis. My pulmonologist did not offer TTO as an alternate method of LTOT. I researched oxygen therapy on the Internet and found Transtracheal Systems. I contacted John Goodman, RRT, and after I explained my situation, he referred me to Dr Michael Schwartz at National Jewish Health in Denver, Colorado. Dr Schwartz spent a great deal of time with me on the telephone, but I felt Denver’s altitude might be problematic for me. I sought established transtracheal programs in Texas, New Mexico, and Arizona without success.

I then located an otorhinolaryngologist in Phoenix, Arizona, who had experience performing the (preferred) Lipkin surgical procedure, so I went to Phoenix. The procedure went very well, and I returned to my home in El Paso, Texas. After 10 days, I started changing my catheter per protocol and was able to do just fine. I am back now to most normal activities, including golf twice a week, pulmonary rehabilitation twice weekly, and more.

Before TTO, my hemoglobin level was 17.5, and my hematocrit value was 51%; today, my hemoglobin level is 14.9, and my hematocrit value is 40.9%. I require a setting of 2 while sedentary and 3 when ambulatory or exercising using a liquid oxygen portable delivery system on intermittent flow. I use continuous flow at 2.5 L/min for sleep.

TTO requires teamwork, and the pulmonologist is the linchpin. It is the pulmonologist who must know that such a procedure does exist and that it is a viable and often a preferable modality. Patient selection is extremely important, and pulmonologists should know that TTO is not a therapy intended only for the patient with refractory hypoxemia. Finally, the patient must be highly motivated, have some manual skill, and have a great deal of confidence in his or her pulmonologist. Again, I thank CHEST for publishing this excellent article and the authors for their fine work.

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References