settings can result in what is termed NIV failure, when in fact the failure is often due to the omission of optimal NIV interfaces, full ventilatory support settings, and the omission of MAC to prevent airway congestion and pneumonia.4–6,10 Our center routinely extubates patients with neuromuscular diseases who have failed multiple spontaneous breathing trials, to the use of NIV and MAC, rather than resort to tracheotomy.4,6,7

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Response
To the Editor:

We appreciate the comments of Drs. Cheng and Bach on our review1 of nocturnal noninvasive ventilation. We are well aware of the successful application of continuous noninvasive ventilation to selected patients with neuromuscular disease,2 as well as the writers’ extensive published experience on these techniques.3,4 However, our review focused on nocturnal applications of noninvasive ventilation, and a discussion of continuous use was beyond our scope. Also, we agree that the mouthpiece interface has a role in management of noninvasive ventilation, but space limitations precluded our discussing it because it plays a much smaller role in providing noninvasive ventilation during sleep than nasal or full face masks. Finally, we advocate the use of manually or mechanically assisted coughing methods for patients with weakened cough. We briefly discussed this in our review and referred to the work of Bach.4

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Dysglycemia in Critically Ill Patients From Medicine

To the Editor:

I read with interest the article in CHEST (June 2008) by Hirshberg and colleagues.1 I was wondering whether the effects of medications on glucose metabolism are underestimated.2–4 Medications that are commonly prescribed in the ICU (eg, β-blockers, thiazide diuretics, and furosemide) could precipitate hyperglycemia. Gatifloxacin is widely used, but the glycemic effect of fluoroquinolone was reported4 after the study by Hirshberg et al1 was published. Perhaps, if the authors focus more on these medications, they might discover that the top 10 factors contributing to hyperglycemia that were cited in the article have changed.

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Response

To the Editor:

Dr. Kittisupamongkol highlights medications as one of the many factors contributing to the disruption of blood glucose homeostasis in the critically ill patient. Commonly prescribed medications in the ICU likely influence glucose and insulin metabolism.1 Our survey was meant to elucidate critical care practitioners' opinions about hyperglycemia, its frequency, and the factors they believe influence blood glucose levels.2 Our survey did not individually address each medication commonly used in the ICU, though we did try to account for medications known to induce peripheral insulin insensitivity (glucocorticoids and vasoactive medications).3 Our survey reflects the opinions of North American intensive care practitioners. Question 3.2 of the survey asked what our respondents thought were the most important factors that contribute to hyperglycemia in the ICU setting. The options did not include an exhaustive list of commonly prescribed medications, but did allow for an “other” box with free text input. Very few respondents ranked the “other” box as a major contributor to hyperglycemia. The use of gatifloxacin in our respondent’s patient population was not addressed. The effects of medications on blood glucose metabolism may be underestimated by ICU practitioners, but we reported the 10 factors that they thought contributed most significantly to hyperglycemia.

Accounting for each medication given to a critically ill patient and its overall metabolic effects presents a challenge for even the most astute clinician. All too often, we focus on one problem and a medication to treat it, and forget to account for its side effects. Although stress hyperglycemia in the critically ill patient is a seemingly simple issue, Dr. Kittisupamongkol’s statement reminds us how clinician perspective and choice of another medication can influence the understanding and treatment of hyperglycemia. The critical care community is currently struggling to determine the best balance for patients between hyperglycemia and hypoglycemia. I would suggest that the climate is ripe for more prospective studies that account for the medications prescribed, the total number of calories ingested, the total doses of insulin administered, as well as the blood glucose target achieved.

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Smoking Cessation Counseling in Orthodox Jewish Populations

To the Editor:

Smoking among Orthodox Jewish populations in the United States remains high despite increased awareness of its harmful effects and increased rabbinical community-wide edicts forbidding smoking publicly and privately.1 Prominent deciders of Jewish law did not prohibit smoking as recently as the 1980s, citing insufficient scientific evidence that smoking is the direct cause of all of a patient’s health problems and in fact may have some salutary effects.2 However, over the past 2 decades, the increase in medical knowledge proving smoking as harmful and lifethreatening has prompted many in rabbinic circles to prohibit smoking. Regardless, smoking continues in Orthodox populations today, attributable to the lag time between rabbinical edicts and their implementation into the workings of Orthodox Jewish socioreligious society, smokers’ reliance on older (and sometimes obsolete) rabbinical edicts permitting smoking, and still present community acceptance of smoking.

Yet, as communities become more aware of the ill effects of smoking and more rabbinical courts issue prohibitions against smoking, a shift against smoking has begun to occur in many Orthodox Jewish communities. Thus, the Orthodox Jewish smokers will find increasing pressure to cease the habit. While this will likely cause a sharp decline in overall smokers, those who have difficulty quitting will be socially and religiously outcast for their defiance of Jewish law and may very likely seek professional help to quit.

Therefore, it is important that a physician counseling Orthodox Jewish patients on smoking cessation be aware of the arguments in Jewish law for and against the permissibility of smoking, especially the recent decisions that prohibit tobacco use.3 Furthermore, physicians should be sensitive to patients attempting to quit as they are aware of both the negative health effects of smoking and its religious prohibition, yet maintain their habit. Lastly, as Judaism places an emphasis on family, the physician should encourage family or group therapy during attempts at smoking cessation and engage in discourse with community leaders to stem negative public attitudes that may emerge against a person still smoking despite its prohibition.

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