EXCLUDED PATIENTS

The principle of the BLUE protocol, which is designed to provide one profile, yielding one ultrasound diagnosis, subsequently correlated with one final diagnosis, which we retained as the “gold standard,” is to prioritize items. For this methodological reason, patients with no or several diagnoses were purposely excluded from the study (n = 41). However, all patients had a precise profile.

Patients Without a Diagnosis

The profiles indicated pneumonia in seven cases, edema in six cases, and COPD/asthma in three cases. In these precise cases, the BLUE protocol adds new information to the traditional approach. It is logical to extrapolate that such patients will benefit from this information.

Patients With Two Diagnoses

The B profile was seen in nine patients with edema plus pneumonia, and in two patients with edema plus COPD; the C profile was seen in one patient with edema plus pneumonia; the A/PLAPS profile was seen in one patient with edema plus COPD, one patient with edema plus phrenic paralysis, and one patient with pneumonia plus laryngeal dyspnea; and the A/PLAPS profile plus venous thrombosis was seen in one patient with pneumonia plus embolism. Therefore, the BLUE protocol established one of the two diagnoses in 87.5% of cases.

Rare Diagnoses

These are the very patients (9 of 269 cases [see Table 1 in our article!] that may have slightly modified the value of the BLUE protocol. We stress that rare diagnoses are not necessarily difficult diagnoses. Patients with massive pleural effusion can be managed without the BLUE protocol. Rare diagnoses were excluded in order to simplify our algorithm. We remind readers that the BLUE protocol aimed to validate an ultrasound approach the value of which is to be associated with the usual initial data. This synthesis provides accurate diagnoses in nearly all cases, decreasing the need for CT scanning.

When rare or double diagnoses are suspected by the usual initial approach, the BLUE protocol can be enriched with other data (eg, unpublished lung ultrasound signs or echocardiography findings). This extended BLUE protocol would increase the potential of the ultrasound, although to the detriment of simplicity.

COPD, Normoxia, and Early Desaturation

To the Editor:

I read with utmost interest the article by Drummond et al1 recently published in CHEST (September 2008). After a retrospective analysis, the authors confirm that patients with COPD who are hypoxia free at rest but have desaturation during exercise are at higher risk than those who do not have desaturation in spite of the fact that continuous oxygen therapy is not followed by a significant survival improvement when compared to a group without oxygen therapy. The problem is that the authors do not explain why oxygen therapy was indicated and, what is more important, they did not analyze the desaturation time in the 6-min walking test.

Our recently published article2 showed that only those patients with a time to desaturation of 1 min (early desaturators) also desaturate during the 24-h oximetry. However, late desaturators (patients with a time to desaturation > 3 to 30 min) do not have desaturation during a 24-h oximetry. It could thus very well be

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that the patients of Drummond et al\(^1\) were late desaturators in whom oxygen therapy may not have produced the benefit it provides to early desaturators.

Finally, although Gorecka et al\(^3\) did not find any improvement in the survival rate of patients with COPD and moderate hypoxia treated with oxygen therapy, they did not analyze the desaturation during the walking test either. At any rate, the effects of oxygen therapy in patients with COPD, normoxemia at rest, and early desaturation in the 6-min walking test remain to be evaluated.

_Ignacio García-Talavera, MD_  
_Armando Aguirre-Jaime, PhD_  
_Respiratory Department, Research Unit_  
_Hospital Universitario Canarias_  
_Tenerife, Spain_

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The authors have no conflicts of interest to disclose.

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Correspondence to: Ignacio García-Talavera, MD, Candelaria Hospital, El Rosario 145, Santa Cruz, Spain 38010; e-mail: igarmark@gobiernodecanarias.org

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Response

To the Editor:

We thank Garcia-Talavera and colleagues for their interest in our article published in _CHEST_ (September 2008).\(^3\) Our retrospective analysis of the National Emphysema Treatment Trial (NETT) demonstrated that participants with resting normoxia and exercise desaturation had worse disease severity and survival than those without exercise desaturation, despite the use of continuous supplemental oxygen. Garcia-Talavera and colleagues commented that the indication for oxygen therapy was not fully described in our report. Per the NETT protocol, exercise desaturation was determined by a treadmill walking test conducted prior to the 6-min walk test, not by monitoring during the 6-min walk test. The time to desaturation on the treadmill test was collected; however, we did not analyze these data.

Importantly, participants in the NETT could receive oxygen prescriptions through rehabilitation centers or their primary care physician, thus making it difficult to collect specific information on the indications for oxygen therapy. In this sense, the NETT mimicked the challenges of monitoring oxygen prescription in the course of routine clinical practice, where oxygen therapy can be initiated by many different health-care providers.

Studies such as that performed by Garcia-Talavera and colleagues\(^4\) will advance our understanding of the role of oxygen therapy in patients who fall outside of established indications. The findings of our analysis emphasize the need for prospective clinical trials to characterize the factors that predict which COPD patients may benefit from supplemental oxygen. From such studies we may eventually refine our current indications for oxygen therapy.

M. Bradley Drummond, MD, MHS  
Robert A. Wise, MD, FCCP  
_The Johns Hopkins University School of Medicine_  
_Baltimore, MD_

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The authors have no conflicts of interest to disclose.

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Correspondence to: M. Bradley Drummond, MD, Division of Pulmonary and Critical Care Medicine, The Johns Hopkins University School of Medicine, 5501 Hopkins Bayview Circle, JHACC 4B, 70, Baltimore, MD 21224; e-mail: mdrummo3@jhmi.edu

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Notice of Duplicate Publication: Chest 2001; 120(suppl):114S–117S

In a Supplement to the September 2001 issue of _CHEST_, the text of an article by Couch, “Treatment With Tobramycin Solution for Inhalation in Bronchiectasis Patients With _Pseudomonas aeruginosa_” [Chest 2001; 120(suppl):114S–117S], overlaps significantly with the content of an article published earlier in the _American Journal of Respiratory and Critical Care Medicine_ by Barker et al, “Tobramycin Solution for Inhalation Reduces Sputum _Pseudomonas aeruginosa_ Density in Bronchiectasis” (Am J Respir Crit Care Med 2000; 162:481–485). As such, the Editors of _CHEST_ have determined that the 2001 Chest article should be categorized as a duplicate publication.