(or relevant analogs), the list of suggested components includes the hydrophilic surfactant proteins SP-A and SP-D, antioxidants, protease inhibitors, phospholipase inhibitors, phospholipase-resistant phosphonolipids, and anticoagulants. Designing the optimal surfactant is clearly a challenging task!

Roger G. Spragg, MD
University of California San Diego and San Diego VA Healthcare System
La Jolla, CA
Friedemann J. H. Taut, MD
Nycomed
Konstanz, Germany
Andreas Günther, MD
Justus-Liebig-University
Giessen, Germany
Gerd Rippin, PhD
Omnicare Clinical Research
Cologne, Germany

Dr. Taut is an employee of Nycomed, the manufacturer of Venticute; Drs. Rippin and Spragg have contractual and consulting relationships, respectively, with Nycomed. Dr. Günther serves as a consultant to Nycomed, he has a patent application pending for research related to the manuscript, and is a member of a scientific advisory board in the Venticute study. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (www.chestjournal.org/site/misc/reprints.xhtml). Correspondence to: Roger G. Spragg, MD, University of California, San Diego, Department of Medicine, 15732 Mercedo Dr, Del Mar, CA 92014-3416; e-mail: rjspagg@ucsd.edu

DOI: 10.1378/chest.09-0787

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Perioperative Epidural Analgesia and Prevention of Ventilator-Associated Pneumonia

To the Editor:

I read with great interest the article by Bouza et al1 in CHEST (November 2008) and the accompanying editorial by Craven and Hjalmarson.2 I celebrate both for showing ways to prevent ventilator-associated pneumonia (VAP).

According to the editorial,2 interventions such as continuous aspiration of subglottic secretions, colloidal silver-coated endotracheal tubes, sedative vacation, and targeted antibiotic therapy are capable of reducing the incidence of VAP. Surprisingly, the use of perioperative epidural analgesia was not even mentioned.

The use of epidural analgesia provides better analgesia compared with parenteral opioids,4 allowing early postoperative extubation. It has recently been shown4 that it also protects against pneumonia following abdominal or thoracic surgery.

Bouza et al1 did not mention the use of perioperative epidural analgesia in their patients. Did they ever consider the use of this technique? The use of an appropriate reference group with a specific condition must be clearly specified to consider component causes of VAP.5

Gonzalo Tornero-Campello, MD
Hospital General Universitario de Elche
Elche, Spain

The authors have reported to the ACCP that no significant conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (www.chestjournal.org/site/misc/reprints.xhtml). Correspondence to: Gonzalo Tornero-Campello, MD, Hospital General Universitario de Elche, Anesthesiology and Reanimation, Camí de la Almazara, s/n, Elche, Spain; e-mail: gtorrenc@hotmail.com

DOI: 10.1378/chest.08-2829

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Response

To the Editor:

We appreciate the interest of Tornero-Campello et al in our recent article in CHEST (November 2008)1 related to the value of continuous aspiration of subglottic secretions. They requested information regarding the use of thoracic epidural anesthesia (TEA), which they seem to consider a standard of care.

We did not use TEA in our daily practice because no evidence has suggested that TEA improves a patient’s outcome, as has been concluded by two metaanalyses.2,3 TEA provides better analgesia and allows earlier tracheal extubation but does not reduce the length of hospital stay after coronary artery bypass surgery.4–6 TEA is probably not needed for pain control in patients undergoing cardiac surgery (which can be managed with conventional analgesia) or fast track (which can be achieved with short-acting IV or inhalational agents).7

TEA is a procedure that is usually applied during the initial 48 h after surgery, whereas ventilation-associated pneumonia (VAP) always occurs > 48 h after intubation. The clinical impact of a few hours delay in the time until extubation on a decrease in the incidence of VAP is far from proven. In our study, the greatest benefit of continuous aspiration of subglottic secretions was observed in the group of patients who...