Finally, the follow-up testing of mediastinal and abdominal adenopathies following tumor resection could help to better define the nature of the association between granulomatous inflammation and cancer in this case.

Almerico Marruchella, MD, FCCP
Istituto Nazionale per le Malattie Infettive “L. Spallanzani”
Rome, Italy

The author has 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.

© 2009 American College of Chest Physicians. 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: Almerico Marruchella, MD, FCCP, Istituto Nazionale per le Malattie Infettive, Respiratory Endoscopy Unit, Via Portuense 292, Roma 00149, Italy; e-mail: almx@libero.it

DOI: 10.1378/chest.09-0472

REFERENCES


Response

To the Editor:

We appreciate the comments made by both Drs. Reich and Marruchella regarding our patient with the synchronous diagnosis of systemic sarcoidosis and lung cancer. The focus of our report was to highlight the challenges of correctly staging a patient with a lung malignancy and diffuse lymph node inflammation consistent with sarcoidosis. Sarcoïd-like reactions (SLRs) have long been associated with malignancy and are thought to be secondary to an immunogenic response to the cancer cells. The granulomas are typically found adjacent to the tumor or lymphatic drainage route. SLRs have also been reported with metastatic breast cancer and invasive adenocarcinoma of the colon. In these cases, the patients’ mediastinal adenopathy resolved with cancer therapy. Debate remains over an increased risk of malignancy for those patients with sarcoidosis. There have been varying rates of both lung cancer and lymphoma diagnosed in sarcoid patients. Clearly our patient’s significant tobacco abuse history outweighed any marginal increased malignancy risk from potentially long-standing sarcoidosis.

Our patient demonstrated diffuse tree-in-bud opacities, mediatinal adenopathy, and increased metabolic activity seen on CT/PET scanning. He had also remote inguinal adenopathy that was not sampled. His surgical pathology after adjuvant chemotherapy followed by right upper lobectomy revealed no lymphatic or vascular invasion by his tumor. All 13 lymph nodes sampled during surgery demonstrated noncaseating granulomas without malignant cells; the pulmonary parenchyma not adjacent to the tumor also had diffuse noncaseating granulomas. The findings of mediastinal adenopathy, tree-in-bud opacities, and increased metabolic activity seen on CT/PET scanning remained stable and was present on all subsequent imaging studies. Repeat bronchoscopic lymph node sampling failed to reveal malignant cells. For these reasons, we feel our patient truly does have synchronous diagnoses of sarcoidosis and lung cancer, and not an SLR related to cancer. One should not be persuaded away from a diagnosis of malignancy when noncaseating granulomas are present. Also, one should employ thorough mediastinal lymph node sampling when there is increased lymph node metabolic activity with a known malignancy.

Regarding the temporal sequence of the patient’s tumor, it is true the patient had a sizable tumor burden and invasion. He did not undergo routine chest radiographs prior to diagnosis as this is not standard practice for military aviators. Our patient initially presented with thoracic and scapular pain, which prompted the chest radiograph. The doubling time argument and presumed long-standing tumor is not valid. There are numerous reports and personal experiences where a small nodule may “take off,” rapidly enlarge, and become an invasive malignancy.

Thomas B. Zanders, DO
Michael Morris, MD, FCCP
Brooke Army Medical Center
Fort Sam Houston, TX
Matthew McNeil, MD
William Beaumont Army Medical Center
El Paso, TX

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.

© 2009 American College of Chest Physicians. 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: Thomas B. Zanders, DO, Brooke Army Medical Center, Pulmonary Critical Care Medicine, 3851 Roger Brooke Dr, San Antonio, TX 78234; e-mail: thomas.zanders@amedd.army.mil

DOI: 10.1378/chest.09-1013

REFERENCES


The Use of Fospropofol During Bronchoscopy

To the Editor:

We read in a recent issue of CHEST (January 2009) the editorial entitled ‘The Old and New of Sedation for Bronchos-
copy” and were greatly concerned by the comments regarding the new sedative/hypnotic agent fospropofol disodium (Lusedra; Eisai Corporation; Woodcliff Lake, NJ). In the opening paragraph of this editorial, the author discussed several important reasons to provide safe and effective sedation during bronchoscopic procedures, including the ability to perform advanced diagnostic and therapeutic procedures, and the increased likelihood that the patient will undergo additional procedures. In these statements, we completely agree with the author and his intent; however, we believe he has missed the mark in regard to safety when he suggests that fospropofol is an entirely new drug that should not be subjected to the same rigorous patient safety standards as other general anesthetic agents.

Fospropofol is a water-soluble prodrug that is metabolized by the liver into its active form, the sedative/hypnotic agent propofol. Propofol (and fospropofol) have powerful physiologic effects including the possibility of inducing significant hemodynamic and respiratory depression, which, if not detected and treated aggressively by a clinician trained to recognize these effects, could prove to be disastrous to the very patients we are trying to benefit.2

Recently, the American Society of Anesthesiologists (ASA), the largest association of physicians dedicated to raising and maintaining the standards of the medical practice of anesthesiology in the United States sent a letter3 to the US Food and Drug Administration (FDA) requesting specific labeling for fospropofol similar to the labeling for propofol. In response to ASA member testimony before the FDA and at the request of patient safety groups, the FDA, in December 2008, approved fospropofol with the following bolded labeling, as suggested by the ASA4: “LUSEDRA should be administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the diagnostic or therapeutic procedure. Patients should be continuously monitored during sedation and through the recovery process for early signs of hypotension, apnea, airway obstruction, and/or oxygen desaturation. Facilities for providing cardiopulmonary resuscitation must be immediately available.”

We believe, therefore, that the use of fospropofol, while potentially beneficial to patients undergoing bronchoscopy evaluations and other complex therapeutic and diagnostic interventions, should only be used as approved by the FDA and with the highest regard for patient safety.

John Thomas McLarney, MD
Kevin Wayne Hatton, MD
Matthew J. Swan, MD
University of Kentucky College of Medicine
Lexington, KY

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.

© 2009 American College of Chest Physicians. 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: Kevin Wayne Hatton, MD, N-202 UKMC, 800 Rose St, Lexington, KY 40536; e-mail: khchatt2@email.uky.edu

DOI: 10.1378/chest.09-0499

REFERENCES


Response

To the Editor:

I appreciate the comments in response to my editorial1 provided by Drs. McLarney, Hatton, and Swan regarding fospropofol and patient safety. All physicians, including pulmonary and critical care physicians performing bronchoscopy, should indeed be concerned with patient safety. I would agree with the statement that fospropofol can have significant respiratory and hemodynamic depression, which can be disastrous for the patient if not detected and treated aggressively. However, this is potentially true for all sedative medications used in the bronchoscopy suite.

I believe the available data suggest that fospropofol can be used safely for moderate sedation without anesthesia monitoring. In the study by Silvestri and colleagues2 involving 252 patients undergoing bronchoscopy, fospropofol combined with fentanyl was efficacious, with hypoxemia occurring in 14.3% of patients and hypotension in 3.2% of patients. Most patients responded to increased oxygen flow and stimulation. One patient required 100% oxygenation by facemask, and one patient required bag-valve mask ventilation; both were in the 6.5 mg/kg group. This is similar to other studies of sedation for bronchoscopy. In a study3 of 101 patients undergoing colonoscopy who received varying doses of fospropofol with 50 µg of fentanyl, two episodes of hypoxemia occurred, both in the 6.5 mg/kg group. Additional studies comparing fospropofol with sedation regimens typically used for bronchoscopy, such as midazolam plus fentanyl, should be performed to compare the efficacy and safety of fospropofol with those of currently used agents. These data, however, are unlikely to change the US Food and Drug Administration labeling for fospropofol. The use of propofol by gastroenterologists has been an area of controversy and political jousting in the past.4

I would agree with the US Food and Drug Administration labeling for fospropofol5 that “patients should be continuously monitored during sedation and through the recovery process for early signs of hypotension, apnea, airway obstruction, and/or oxygen desaturation. Facilities for providing cardiopulmonary resuscitation must be immediately available.” This should be, and I believe is, the standard of care for most bronchoscopy suites in the United States. Pulmonologists, in my opinion, are capable of managing the airway should the patient temporarily lapse into deep sedation or a state of general anesthesia and are capable of dealing with hypoxemia during bronchoscopic procedures. As such, I disagree with the labeling that fospropofol should be administered “only by persons trained in the administration of general anesthesia.” I believe fospropofol can be safely used by pulmonary and critical care physicians in the bronchoscopy suite.

Michael A. Jantz, MD, FCCP
University of Florida
Gainesville, FL

Dr. Jantz has 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.

© 2009 American College of Chest Physicians. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (www.chestjournal.org/site/misc/reprints.xhtml).