tional drawbacks of the interventions they advocate, as well as the intended benefits. While the correspondent may believe it to be irresponsible to discuss the potential for antibiotic prescribing policy to have unintended consequences, we believe that it would be irresponsible not to do so.

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REFERENCES

Bronchscopy in China

The Chinese Society of Respiratory Diseases Survey

To the Editor:

In order to investigate the clinical application of bronchoscopy in China, the Chinese Society of Respiratory Diseases conducted a retrospective survey in 2008. Questionnaires were sent to 40 hospitals of the Chinese Society of Respiratory Diseases in 24 provinces of China to investigate bronchoscopic procedures during 2007. They were completed and returned from 30 hospitals (75%) in 21 provinces. The following results were determined by the statistics reported in these questionnaires.

All of the hospitals possessed flexible bronchoscopes, but only seven hospital possessed rigid bronchoscopes. All of the hospitals required that patients sign informed consent forms before undergoing bronchoscopy. All of the hospitals performed a radiograph or CT scan before performing bronchoscopy. Twenty-four hospitals performed ECG, 23 hospitals examined coagulation profiles, 21 hospitals performed a CBC count, 16 hospitals examined hepatitis B markers, and 8 hospitals tested for HIV before the patient underwent bronchoscopy. Atropine was administered by 19 hospitals. Sedatives were administered by four hospitals, three of which also used atropine. Ten hospitals used no premedication. Nineteen hospitals performed bronchoscopy with all patients receiving topical anesthesia. Eleven hospitals performed bronchoscopy with most patients receiving topical anesthesia, and a few patients receiving general anesthesia. For topical anesthesia, 12 hospitals used a nebulizer, 8 hospitals used a spray, and 8 hospitals used both. The other two hospitals injected lidocaine through the bronchoscope over the glottis. An emergency cart was available in the examination room in 28 hospitals. During bronchoscopy, pulse oximetry was the most widely used monitoring method; some hospitals also monitored ECG and BP. Most hospitals used the nasal route to perform routine bronchoscopy. Some hospitals used the oral route for patients with a narrow nasal cavity. Twenty-three hospitals used a sink to wash the bronchoscopes, and 27 hospitals used glutaraldehyde to disinfect them.

The total number of flexible bronchoscopic procedures performed by the 30 hospitals during 2007 was 39,253, and the average number of procedures was 1,308 for one hospital. Diagnostic bronchoscopic procedures included brush and forceps biopsy, transbronchial lung biopsy, BAL, and transbronchial needle aspiration. They were more widely used than therapeutic bronchoscopy. Table 1 shows the number of therapeutic flexible bronchoscopic procedures performed. The use of airway stents by bronchoscopists (15.3%) was similar to the corresponding

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Hospitals Involved</th>
<th>Patients, Total No.</th>
<th>Range</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rinsing and draining of infection</td>
<td>28</td>
<td>4,353</td>
<td>10 to approximately 1,200</td>
<td>155.5</td>
</tr>
<tr>
<td>Microwave coagulation</td>
<td>10</td>
<td>340</td>
<td>4 to approximately 146</td>
<td>34.0</td>
</tr>
<tr>
<td>Balloon dilatation</td>
<td>18</td>
<td>670</td>
<td>1 to approximately 344</td>
<td>48.3</td>
</tr>
<tr>
<td>Foreign-body removal</td>
<td>25</td>
<td>515</td>
<td>1 to approximately 85</td>
<td>20.6</td>
</tr>
<tr>
<td>Afterloading catheter placement</td>
<td>2</td>
<td>44</td>
<td>14 to approximately 30</td>
<td>22</td>
</tr>
<tr>
<td>Laser</td>
<td>3</td>
<td>51</td>
<td>3 to approximately 30</td>
<td>17</td>
</tr>
<tr>
<td>Cryotherapy</td>
<td>10</td>
<td>365</td>
<td>2 to approximately 126</td>
<td>36.8</td>
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<tr>
<td>Electrocautery</td>
<td>14</td>
<td>866</td>
<td>5 to approximately 314</td>
<td>61.9</td>
</tr>
<tr>
<td>Argon plasma coagulation</td>
<td>10</td>
<td>611</td>
<td>10 to approximately 222</td>
<td>61.1</td>
</tr>
<tr>
<td>Stent placement</td>
<td>19</td>
<td>410</td>
<td>1 to approximately 95</td>
<td>21.6</td>
</tr>
<tr>
<td>Photodynamic therapy</td>
<td>3</td>
<td>7</td>
<td>1 to approximately 3</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Table 1—Total Number of Therapeutic Flexible Bronchoscopic Procedures Performed in 2007

Correspondence
Trees Don’t Grow in the Lungs!

To the Editor:

We read with interest a recent article1 on the BBC Web site of a 5-cm fir tree discovered by doctors in the lungs of a Russian botanist who underwent ressection for a “lung tumor” while presented with chest pain. The surgeon who operated on him commented that “The branch was green, as if it had just been taken from the wood. It’s still a mystery how the tree got in there.” It was thought that the patient had inhaled a seed, which then grew into a tree inside his body! Two pulmonologists from the United States commented that “The branch was green, as if it had just been taken from the wood. It’s still a mystery how the tree got in there.”

Coincidentally, in another recent article published around the same time in the April 2009 issue of the Journal of Bronchology and Interventional Pulmonology, Davis et al3 described the case of a 45-year-old man in whom recurrent pneumonias developed 26 years after an impaling accident on a tree sucker and who was found to have a 5-cm splinter from a piece of wood in his right mainstem bronchus following a thoracotomy. The article was entitled “A tree grows in bronchus”; yet, the incident on aspiration was well documented. The title of the article was chosen to express the patient’s perception and to make it “catchy.”

We would like to bring to the attention of readers that trees do not grow in the lungs. To the best of our knowledge, there has never been a single report in the medical literature of seeds and/or plants growing in humans. If they did, watermelon seeds and peanuts,4,5 which are the most commonly aspirated foreign bodies, would be growing out of control from our lungs. Moreover, it makes no biological sense that in the absence of sunlight and appropriate nutrient medium, photosynthesis and germination of a seed can take place. Foreign-body aspiration often goes undetected if the initial choking episode is not obvious. In adults, a reason for the lack of acute symptoms may be the larger caliber of airways, resulting in most foreign bodies lodging in distal airways. Seeds and plant material by themselves, however, are radiolucent, and any radio-opacity seen is likely from complications. A high index of suspicion is required. A bronchoscopic examination of the airway will establish the diagnosis.

In the realm of scientific observation, the adage “trees do not grow in the lungs” indeed holds true in every sense.

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REFERENCES


Could Fiberoptic Bronchoscopy and CT Lung Scan Differentiate Ventilator-Associated Tracheobronchitis From Ventilator-Associated Pneumonia?

To the Editor:

I read with interest the article in CHEST (February 2009) by Dr. Craven and colleagues1 on ventilator-associated tracheobronchitis (VAT). In this general review, the authors elegantly discussed recent findings on the impact of targeted antibiotic therapy on patient outcomes.2,3 They outlined the difficulty in differentiating VAT from ventilator-associated pneumonia (VAP) and suggested fiberoptic bronchoscopy and CT lung scan to confirm the diagnosis of VAP. However, some clarification would be helpful for ICU physicians.

The authors stated that quantitative samples obtained from the distal airway using bronchoscopic or nonbronchoscopic lavage or specimen brush were used to confirm VAP. Do the authors...