important for the accurate selection of patients who will benefit from targeted therapy. In our study, the cell pellet derived from a needle wash solution and stored frozen samples were used to avoid the risk of false-positive results due to the fragmented and low amount of DNA. As Dr Fleury-Feith and colleagues suggest, using frozen cells will ensure current optimum technical conditions.

On the other hand, there have been very few articles on the optimal storing methods for samples obtained by needle biopsy techniques for molecular testing. The development of an optimal specimen-handling technique and tumor banking protocol for molecular testing is mandatory for personalized treatment based on biomarker-driven information. Although we agree with the importance of the collection and analysis of fresh-frozen samples from endobronchial ultrasound-guided transbronchial needle aspiration, this may not always be possible in a community hospital. There is a need to develop a reliable, high-throughput analysis using formalin-fixed paraffin-embedded samples. The MassARRAY system (Sequenom Inc; San Diego, California) and molecular inversion probe microarrays may be powerful tools for the detection of comprehensive aberrant gene mutation within lung cancer.

In conclusion, we are witnessing a paradigm shift in targeted cancer therapy using selective kinase inhibitor in patients with lung cancer. In addition to the exploration of a novel target molecule, we need to continuously seek a better way to sample and preserve microsamples for molecular analysis.

Rapid Pleurodesis
An Outpatient Alternative

To the Editor:

We read with great interest in a recent issue of CHEST (June 2011) the report from Reddy et al. who describe a pilot study of rapid pleurodesis by combining medical thoracoscopy and talc poudrage with simultaneous tunneled pleural catheter (TPC) placement. In their report, they describe a success rate of 92%, with removal of the TPC at a median of 7.54 days. Furthermore, they have a median hospitalization time of 1.79 days, (mean 3.19). This is clearly a significant advance over the usual 5 to 7 days of hospitalization required during standard chemical pleurodesis.

We used a similar protocol of simultaneous chemical pleurodesis with talc and TPC placement. This procedure evolved as patients with malignant pleural effusions have an average survival of a few weeks to months, so the need for expedient procedures that improve quality of life, minimize discomfort, and decrease the length of stay are of paramount importance. To date, we have treated eight cases with a few differences from those described by Reddy et al (Table 1). Our standard procedure is a single-port thoracoscopy with parietal pleural biopsies, removal of pleural fluid, and instillation of 4 to 6 g of talc (Sclerosol). We did not leave a thoracostomy tube after the procedure. We placed the TPC on continuous suction for approximately 4 to 12 h, and patients were discharged home the same day of the procedure. We instructed the patients to drain the TPC every day for 5 days and then every other day until the next outpatient visit. Reaching similar results to those described by Reddy et al, we have had an excellent pleurodesis rate. The catheters were removed at the time of the follow-up visit in seven patients. Pain control was achieved in all cases with the use of oral opioid analgesics.

We agree with Reddy and colleagues that rapid pleurodesis with simultaneous chemical and TPC use should be subject to randomized controlled trials in an effort to change the “state of the art” in management of malignant pleural effusions. We hope our experience with a similar protocol and shorter length of stay will contribute in the accumulation of necessary data to support the feasibility, safety, and effectiveness of rapid pleurodesis.

Erik Folch, MD
Boston, MA
Jose Fernando Santacruz, MD
Houston, TX

Affiliations: From the Division of Thoracic Surgery and Interventional Pulmonology (Dr Folch), Beth Israel Deaconess Medical Center, Harvard Medical School; and the Department of Interventional Pulmonary Medicine (Dr Santacruz), Oncology Consultants, International Cancer Center.

Financial/nonfinancial disclosures: The authors have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

Correspondence to: Erik Folch, MD, Division of Thoracic Surgery and Interventional Pulmonology, Beth Israel Deaconess Medical Center, Harvard Medical School, 185 Pilgrim Rd, Deaconess 201, Boston, MA 02215; e-mail: efolch@bidmc.harvard.edu

© 2011 American College of Chest Physicians. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (http://www.chestpubs.org/site/misc/reprints.xhtml).

DOI: 10.1378/chest.11-1681

www.chestpubs.org

References


Rapid Pleurodesis
An Outpatient Alternative

To the Editor:

We read with great interest in a recent issue of CHEST (June 2011) the report from Reddy et al.1 who describe a pilot study of rapid pleurodesis by combining medical thoracoscopy and talc poudrage with simultaneous tunneled pleural catheter (TPC) placement. In their report, they describe a success rate of 92%, with removal of the TPC at a median of 7.54 days. Furthermore, they have a median hospitalization time of 1.79 days, (mean 3.19). This is clearly a significant advance over the usual 5 to 7 days of hospitalization required during standard chemical pleurodesis.2,3

We used a similar protocol of simultaneous chemical pleurodesis with talc and TPC placement. This procedure evolved as patients with malignant pleural effusions have an average survival of a few weeks to months, so the need for expedient procedures that improve quality of life, minimize discomfort, and decrease the length of stay are of paramount importance.1 To date, we have treated eight cases with a few differences from those described by Reddy et al1 (Table 1).

Our standard procedure is a single-port thoracoscopy with parietal pleural biopsies, removal of pleural fluid, and instillation of 4 to 6 g of talc (Sclerosol). We did not leave a thoracostomy tube after the procedure. We placed the TPC on continuous suction for approximately 4 to 12 h, and patients were discharged home the same day of the procedure. We instructed the patients to drain the TPC every day for 5 days and then every other day until the next outpatient visit. Reaching similar results to those described by Reddy et al1 we have had an excellent pleurodesis rate. The catheters were removed at the time of the follow-up visit in seven patients. Pain control was achieved in all cases with the use of oral opioid analgesics.

We agree with Reddy and colleagues1 that rapid pleurodesis with simultaneous chemical and TPC use should be subject to randomized controlled trials in an effort to change the “state of the art” in management of malignant pleural effusions. We hope our experience with a similar protocol and shorter length of stay will contribute in the accumulation of necessary data to support the feasibility, safety, and effectiveness of rapid pleurodesis.

Erik Folch, MD
Boston, MA
Jose Fernando Santacruz, MD
Houston, TX

Affiliations: From the Division of Thoracic Surgery and Interventional Pulmonology (Dr Folch), Beth Israel Deaconess Medical Center, Harvard Medical School; and the Department of Interventional Pulmonary Medicine (Dr Santacruz), Oncology Consultants, International Cancer Center.

Financial/nonfinancial disclosures: The authors have reported to CHEST that no potential conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

Correspondence to: Erik Folch, MD, Division of Thoracic Surgery, and Interventional Pulmonology, Beth Israel Deaconess Medical Center, Harvard Medical School, 185 Pilgrim Rd, Deaconess 201, Boston, MA 02215; e-mail: efolch@bidmc.harvard.edu

© 2011 American College of Chest Physicians. Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (http://www.chestpubs.org/site/misc/reprints.xhtml).

DOI: 10.1378/chest.11-1681

www.chestpubs.org

References

Table 1—Comparison of Rapid Pleurodesis Experiences

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Our Experience</th>
<th>Reddy et al\textsuperscript{1}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients, No.</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Most common primary site (No.)</td>
<td>Lung (5)</td>
<td>Lung (9)</td>
</tr>
<tr>
<td>Length of hospitalization, median (mean), d</td>
<td>1 (1.5)</td>
<td>1.79 (3.19)</td>
</tr>
<tr>
<td>Length of time with TPC, median (mean), d</td>
<td>16 (21)\textsuperscript{a}</td>
<td>7.54 (16.65)</td>
</tr>
<tr>
<td>Need for thoracostomy tube</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Violation of visceral pleura</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Technique used to determine likelihood of pleurodesis</td>
<td>Postthoracentesis radiograph</td>
<td>Pleural manometry</td>
</tr>
<tr>
<td>Immediate postoperative drainage technique</td>
<td>TPC to continuous suction at ( -20 \text{ cm H}_2\text{O} )</td>
<td>24F Chest tube to continuous suction at ( -20 \text{ cm H}_2\text{O} )</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>General anesthesia</td>
<td>Moderate sedation</td>
</tr>
<tr>
<td>Procedure-related complications</td>
<td>0</td>
<td>Fever (2), empyema (1)</td>
</tr>
<tr>
<td>Procedure-related deaths</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Patients who died with TPC in place, No. (%)</td>
<td>1 (12.5)</td>
<td>4 (13)</td>
</tr>
<tr>
<td>Clogging of TPC</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

TPC = tunneled pleural catheter.

\textsuperscript{a}Time to office visit determined removal of TPC.

References


Physician Specialty as a Source of Heterogeneity in the Care of Patients With COPD

To the Editor:

Patients with COPD frequently are cared for by nonrespiratory specialists, and specialty might affect the approach to COPD.\textsuperscript{1-4} The Linking Innovation and Knowledge in COPD (LINK) study comparatively assessed the clinical practice of three categories of Italian specialist physicians: 80 pneumologists, 81 geriatricians, and 52 internists completed an online questionnaire (e-Appendix 1) that explored these specialists’ perceptions of COPD on the basis of individual experience and professional course. Data were analyzed by descriptive statistics, and discriminant analysis was used to compare the approach to COPD of the three specialist groups.\textsuperscript{2,4}

Pneumologists were more aware of specific pathophysiologic aspects of COPD, such as the clinical impact of dynamic hyperinflation (pneumologists, 86%; geriatricians, 54%; internists, 61%) and the phenotypic variants of COPD. Geriatricians more frequently performed multidimensional assessment of patients with COPD (geriatricians, 76.5%; pneumologists, 24%; internists, 28%). COPD-specific health status indexes were routinely used by 54% of pneumologists, 57% of geriatricians, and 45% of internists. Seventy-five percent of geriatricians routinely assessed activities of daily living and instrumental activities of daily living compared with 35% of pneumologists and 39% of internists.

Results from the discriminant analysis are summarized in Table 1. The first discriminant function explained 92% of the variance and had a small Wilks \( \lambda \) (ie, only a small proportion of the variance among groups is not explained by differences among groups). A high eigenvalue further testifies to the strong discriminant power of function 1. The cross-tabulation of actual group membership as defined by the selection criteria and functional group membership resulting from the performance on the questionnaire are reported in Table 2. The majority of geriatricians (84%) and pneumologists (71%) had concordant actual and functional group membership (ie, in their daily practice, they conformed to a highly prevalent group-specific pattern). The same was not true for internists, where only 30% behaved as internists, 40% as pneumologists, and 21% as geriatricians.

A specialty-related approach to COPD characterized the majority of pneumologists and geriatricians and was related to distinctive visions of physiopathology, health status, comorbidity, and modality of assessment of patients with COPD. The attitude of internists toward COPD was highly heterogeneous. Our findings identify selected weaknesses and strengths of the various management styles and might suggest strategies to improve specialty practice as it pertains to COPD management.

Table 2—Cross-Tabulation of Actual Group Membership vs Functional Group Membership

<table>
<thead>
<tr>
<th>Group</th>
<th>Pneumologists</th>
<th>Geriatricians</th>
<th>Internists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumologists</td>
<td>71.3</td>
<td>7.5</td>
<td>21.2</td>
</tr>
<tr>
<td>Geriatricians</td>
<td>4.9</td>
<td>84</td>
<td>11.1</td>
</tr>
<tr>
<td>Internists</td>
<td>40.2</td>
<td>20.7</td>
<td>39.1</td>
</tr>
</tbody>
</table>

Rows indicate actual group membership; columns indicate functional group membership.