the continuation of the procedures. Too many variables, such as
FiO₂, positive end-expiratory pressure, mode of ventilation, postopera-
tive pain management, open vs video-assisted operation, and
so forth, make a statement about the advantage of one strategy
over the other nearly impossible.3 Although Yang et al intended
to show some evidence in favor of a protective strategy, the jury
on this issue is still out.

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site/misc/reprints.xhtml).
DOI: 10.1378/chest.11-1791

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Response

To the Editor:

We thank Dr Djalali for his interest in our recent article1 and
would like to respond to his questions. First, the sample size is
small (n = 50 in each group); there have been no reports, to our
knowledge, comparing the incidences of PaO₂/FiO₂ < 300 mm Hg
and pulmonary complications between the two ventilation stra-
tegies; the sample size was calculated based on previous data,
which showed a difference in postoperative PaO₂/FiO₂ between
the conventional strategy and protective strategy (PV) groups;6
and 47 subjects in each group were required.

Second, as to the comment about having too many variables
(different FiO₂, tidal volume, positive end-expiratory pressure,
mode of ventilation), there are already a number of reports that
used a single element or two elements of PV strategy to see the
effect of each element in relation to lung injury.13,14 We applied
most of the known elements of PV strategy (small tidal volume,
low airway pressure and FiO₂, application of positive end-expiratory
pressure) to see the total effect of PV strategy. Therefore, includ-
ing many variables was essential for our study.

Third, as to the problem in randomization (differences in sur-
geros, postoperative pain control methods, operation methods),
those variables were not statistically different between
the groups. However, we agree that all these factors may have affected
the results to some degree. More strict control of these variables
is ideal, and we will do that in future studies.

Finally, as to the question about changing ventilation mode to
pressure control in 30% of patients of the conventional strategy
group: To keep the peak inspiratory pressure (PIP) < 30 mm H₂O,
which was our protocol, we changed ventilation mode to pres-
sure control in those patients who exceeded this limit. Even
though these patients got the advantage of reduced PIP compared
with their original values, the benefit of PV was still apparent
in our study. These patients were included to show the benefit of
pressure control mode in PIP. We hope our answers to the ques-
tions posed are helpful.

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DOI: 10.1378/chest.11-1943

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for acute lung injury after thoracic surgery for lung cancer.

Diagnostic Performance of
Percutaneous Core-Needle Lung
Biopsy Under CT Scan Fluoroscopic
Guidance for Pulmonary Lesions
Measuring ≤ 10 mm

To the Editor:

We know of two previous reports that have focused on the
diagnostic performance of CT scan-guided fine-needle aspira-
tion biopsy of pulmonary lesions measuring ≤ 10 mm.1,2 To
our knowledge, however, the diagnostic accuracy of CT scan
fluoroscopy-guided core-needle biopsy (Fig 1) for pulmonary
lesions measuring ≤ 10 mm has not been evaluated.

We retrospectively identified 73 patients who underwent per-
cutaneous core-needle lung biopsy under CT scan fluoroscopic
guidance for pulmonary lesions measuring ≤ 10 mm between
October 2002 and June 2009. The biopsy specimen results as well
as the final diagnoses were available in 50 of these patients, and
the results were compared (one lesion per patient). The diagnos-
tic performance was also compared according to the lesion size

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there have been no suspected cases of needle tract disseminations. Four patients (6%) experienced mild hemoptysis, respectively. Eight patients (11%) developed pneumothoraces. In lesions with the longer needle path (<8 mm [n = 22] vs >8 mm [n = 28]), the depth from the lung surface (<25 mm [n = 32] vs >25 mm [n = 18]), and the length of the needle path (<7 cm [n = 35] vs >7 cm [n = 15]), the overall sensitivity, specificity, and accuracy were 90%, 100%, and 94%, respectively (Table 1). The sensitivity and accuracy (Fisher exact test) were not significantly affected by the size of the lesions (<8 mm, 91% and 95%; 9-10 mm, 89% and 93%; P = .86 and P = .70, respectively). The diagnostic sensitivity and accuracy were lower in the lesions deeper from the lung surface (0-25 mm, 100% and 100%; >25 mm, 79% and 83%; P = .06 and P = .017, respectively) and in lesions with the longer needle path (<7 cm, 100% and 100%; >7 cm, 70% and 80%; P = .012 and P = .006, respectively). Eight patients (11%) developed pneumothoraces. One patient required manual aspiration, but the others resolved conservatively. Four patients (6%) experienced mild hemoptysis, which resolved conservatively for all of them. As of this report, there have been no suspected cases of needle tract disseminations.

The diagnostic sensitivity and accuracy in the present study were slightly higher than in the previous two reports that focused on pulmonary lesions measuring ≤10 mm,1,2 which were 82% and 68% in sensitivity and 88% and 79% in accuracy, respectively. We presume that the higher levels of sensitivity and accuracy were the result of the acquisition of core biopsy specimens with the use of three-slice simultaneous CT scan fluoroscopy imaging. The proportion of nondiagnostic results in the present study, two of 52 (4%), was also substantially lower in comparison with the previous two reports using fine-needle aspiration biopsy1,2 (23% and 18%, respectively).

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DOI: 10.1378/chest.11-1821

REFERENCES

Social Work in Adult Critical Care
A National Survey

To the Editor:

Insufficient literature exists about the role of the social worker in critical care.1-4 A 31-question survey to determine the interventions used most often by social workers in adult ICUs was administered to social workers in attendance at the Society for Social Work Leadership in Health Care on April 23, 2009. The survey was administered on paper and through subsequent e-mail invitations. Survey questions were derived from a literature review5 and from the clinical experience of two critical care social workers

Table 1—Comparison of Core Needle Biopsy Results With the Final Diagnoses

<table>
<thead>
<tr>
<th>Biopsy Results</th>
<th>Final Diagnoses</th>
<th>No. of Lesions</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant</td>
<td>Primary lung adenocarcinoma</td>
<td>24</td>
<td>TP</td>
</tr>
<tr>
<td></td>
<td>Metastatic lung tumor</td>
<td>2</td>
<td>TP</td>
</tr>
<tr>
<td>Negative for malignancy</td>
<td>Primary lung adenocarcinoma</td>
<td>3</td>
<td>FN</td>
</tr>
<tr>
<td></td>
<td>Granulomatous inflammation</td>
<td>1</td>
<td>TN</td>
</tr>
<tr>
<td></td>
<td>Cryptococcus</td>
<td>1</td>
<td>TN</td>
</tr>
<tr>
<td></td>
<td>Regression on follow-up</td>
<td>2</td>
<td>TN</td>
</tr>
<tr>
<td></td>
<td>Unchanged on follow-up</td>
<td>17</td>
<td>TN</td>
</tr>
</tbody>
</table>

FN = false negative; TN = true negative; TP = true positive.