the continuation of the procedures. Too many variables, such as FIO$_2$, positive end-expiratory pressure, mode of ventilation, postoperative pain management, open vs video-assisted operation, and so forth, make a statement about the advantage of one strategy over the other nearly impossible. \cite{Yang2011} Although Yang et al\cite{Yang2011} intended to show some evidence in favor of a protective strategy, the jury on this issue is still out.

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

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DOI: 10.1378/chest.11-1791

**References**


**Response**

To the Editor:

We thank Dr Djalali for his interest in our recent article\cite{Yang2011} 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 Pao$_2$/Fio$_2$ < 300 mm Hg and pulmonary complications between the two ventilation strategies; the sample size was calculated based on previous data, which showed a difference in postoperative Pao$_2$/Fio$_2$ between the conventional strategy and protective strategy (PV) groups; and 47 subjects in each group were required.

Second, as to the comment about having too many variables (different Fio$_2$, 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.\cite{Michelet2006, Fernández-Pérez2006} We applied most of the known elements of PV strategy (small tidal volume, low airway pressure and Fio$_2$, application of positive end-expiratory pressure) to see the total effect of PV strategy. Therefore, including many variables was essential for our study.

Third, as to the problem in randomization (differences in surgeons, 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 H$_2$O, which was our protocol, we changed ventilation mode to pressure 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 questions posed are helpful.

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DOI: 10.1378/chest.11-1943

**References**


**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 aspiration biopsy of pulmonary lesions measuring ≤ 10 mm.\cite{Licker2003} 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 percutaneous 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 diagnostic performance was also compared according to the lesion size measured.
there have been no suspected cases of needle tract disseminations. which resolved conservatively for all of them. As of this report, conservatively. Four patients (6%) experienced mild hemoptysis, which required manual aspiration, but the others resolved

respectively). Eight patients (11%) developed pneumothoraces.

100% and 100%; respectively) and in lesions with the longer needle path (≥7 cm [n = 35] vs >7 cm [n = 15]). Finally, all 73 cases were reviewed for complications. The patients’ age, gender, lesion size, depth from the lung surface, and length of the needle path were as follows, respectively (range in parentheses): 62 ± 12 years of age (34-81), 31 men and 36 women, 8.6 ± 1.5 mm (4-10), 23 ± 16 mm (0-76), and 64 ± 21 mm (33-125). 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 hemothorax, 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 85% 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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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.

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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.