the continuation of the procedures. Too many variables, such as FiO₂, 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. 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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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 strategies; 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; 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.¹,³ 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, 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 H₂O, 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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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.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 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.
conservatively. Four patients (6%) experienced mild hemoptysis, one patient required manual aspiration, but the others resolved.

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</td>
<td>24</td>
<td>TP</td>
</tr>
<tr>
<td></td>
<td>adenocarcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative for malignancy</td>
<td>Metastatic lung tumor</td>
<td>2</td>
<td>TP</td>
</tr>
<tr>
<td></td>
<td>Primary lung</td>
<td>3</td>
<td>FN</td>
</tr>
<tr>
<td></td>
<td>adenocarcinoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Granulomatous</td>
<td>1</td>
<td>TN</td>
</tr>
<tr>
<td></td>
<td>inflammation</td>
<td></td>
<td></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.

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 biopsy1,3 (23% and 19%, respectively).

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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 review2 and from the clinical experience of two critical care social workers.