Response

To the Editor:

We thank Dr Gibson et al1 for their letter in support of our article advocating greater use of a narrative approach to enhance clinical care for asthma2 and their helpful reference to the Asthma UK survey in support of this.

We agree that asking questions about symptoms and response to treatment is of key importance, and would also emphasize that a narrative approach involves much more than this. It is also about how the skills of open questioning and active listening are used to understand complex storied aspects of clinical work in patients with asthma; this also enables patients to describe the story of their illness in a way that is meaningful for them, allowing them to share decisions on treatment with their clinician (and other health-care providers) and, ultimately, to improve self-care. Falling under the rubric of a narrative approach is the need to explore the use of tone and metaphors in individuals’ narratives of asthma that, we argue, may provide clinicians with a key indicator of how patients are actually living and coping with asthma.

We were primarily interested in investigating this approach to enhance clinical communication between patients (including parents and their children with asthma) and medical or nursing staff. We also agree with Gibson et al1 that the development of school-based, including peer-led, educational programs for children with asthma is a potentially useful way to enhance self-care and improve outcomes. It is certainly of research interest to identify and explore the forms of coping mechanisms employed by young people in managing their asthma, and it is encouraging to learn that research3 has found that engaging the curiosity of school children is an effective method of improving understanding of asthma and its management in this population. Increasing patients’ (both adults and children) confidence in managing their asthma may also facilitate a more patient-centered consultation where both patients and clinicians are able to share their expertise to improve the effectiveness and experience of care.

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References

Therapeutic Role of Endoscopic Resection in Typical, Noninvasive, Carcinoid Tumors

To the Editor:

The article by Raz et al1 in CHEST (April 2015), as well as the comment letter by Schwartz and Henson,2 expanded our knowledge on the natural history of carcinoid tumors. The authors repeat the assumption that surgery is always recommended as first-line treatment of typical carcinoids.3 However, the high tolerability, the very low mortality, and the lack of
conclusive evidence regarding the role of endobronchial treatment challenge this recommendation. 4

Raz et al1 further compared the survival curves of two different lung-sparing resection techniques (lobectomy and sublobectomy) vs a defined no-treatment group that also included a sample (51 of 306) of patients who underwent endoscopic tumor destruction with laser, cautery/fulguration, or otherwise specified procedures. We believe this approach is incorrect. Indeed, endoscopic treatment seems reasonably safe and effective in typical, noninvasive, lymph node-negative carcinoids. 5,6 Although carcinoid recurrence has been shown to occur more frequently in patients managed endoscopically than in surgically treated patients, morbidity and long-term mortality rates are extremely low. In a case series of 35 patients with endoscopically resected carcinoids, Cavaliere et al6 reported no recurrence after a follow-up period of up to 198 months. In another series of 28 patients undergoing endobronchial treatment, the median follow-up was 8.8 years, and the 1- and 10-year survival rates were 89% and 84%, respectively.7 Among survivors, 100% and 94% were disease free at 1 and 10 years.

The endoscopic approach thus seems valuable, at least in selected situations, and worthy of further research, although it should not be considered a nontreatment. It would be very useful to generate a Kaplan-Meier survival curve for the endoscopic treatment group compared with the other groups. Furthermore, a baseline characterization of comorbidity and performance status of patients undergoing endoscopic treatment would clarify which patients are deemed suitable for such a treatment in real-life practice. Finally, in the study by Raz et al,1 only a minority of subjects belonging to the no-treatment group had a centrally located tumor, the only site amenable to endoscopic resection, thus supporting the hypothesis that the carcinoid was not treated because of concurrent conditions.

In conclusion, the valuable data by Raz et al1 should prompt further investigations to highlight the role of endobronchial resection in the treatment of typical carcinoid tumors regarding recurrence and mortality as well as other clinical outcomes such as patient tolerability and quality of life.

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Response

To the Editor:

We thank Scarlata and colleagues for their insightful comments regarding the use of endoscopic techniques in the management of central typical carcinoid tumors as well as their comments on our recent article. 1 As mentioned in their letter, there are institutional series reporting excellent long-term results with endoscopic management.2,3 We did not provide information on endoscopic management in our article because the number of patients was small and we had limited information from the Surveillance, Epidemiology, and End Results Program database. We used these data to assess whether procedures were diagnostic or therapeutic, the specific treatment provided, and the number of times endoscopic procedures were performed for each patient.

References