Thorax 1988;**43**:218

Correspondence

Laser treatment for tracheobronchial tumours: local or general anaesthesia?

SIR,—We fully agree with the conclusions and recommendations of Dr PJM George and his colleagues (September 1987;**42**:656–60) that clinicians planning to undertake bronchoscopic laser treatment should consider a method using general anaesthesia and rigid bronchoscopy. Nevertheless, our experience in 75 patients (172 sessions) receiving bronchoscopic laser treatment for tracheobronchial lesions with a purpose designed rigid bronchoscope[1] and general anaesthesia is at variance with theirs.

In those of their patients treated under general anaesthesia, they say, "the treatments are usually completed within two hours, but can be extended for up to three hours." None of our patients required such a long duration of treatment. The average duration of anaesthesia has been 35 minutes a session, and only exceptionally have patients required endotracheal intubation beyond this time after the completion of the treatment. We believe that (*a*) the long duration of anaesthesia in their patients may be responsible for some at least of their post-treatment complications and (*b*) that their method of using the flexible fibreoptic instrument through the rigid bronchoscope inevitably requires multiple manipulations that will unnecessarily prolong the duration of treatment and anaesthesia.

We also find that the duration of hospitalisation of the patients of Dr George and his colleagues is longer than ours, which is two to three days. Only patients referred to us from distant areas are in hospital from Monday to Saturday, in order to receive two consecutive treatments.

Finally, objective assessment of the results (response to treatment) as presented by the authors must be interpreted with caution and requires additional clarification—that is, while radiological improvement may be achieved immediately or soon after the treatment the improvement in peak expiratory flow rate, if any, is only demonstrable a few days or even a week later. Therefore the point after treatment at which these tests are carried out for comparison with the pretreatment figures is important and should be stated.

K MOGHISSI
ALLISON BUDD
Humberside Cardiothoracic Surgical Centre
Castle Hill Hospital, Cottingham
North Humberside HU16 5JQ

1 Moghissi K, Jessop T, Dench M. A new bronchoscopy set for laser therapy. *Thorax* 1986;**41**:485–6.

**This letter was sent to the authors, who reply below.

SIR,—While most laser bronchoscopists prefer to give treatment under general anaesthesia, the choice of bronchoscopic technique varies between different groups. Although we have no experience with the bronchoscopy set designed by Mr Moghissi and his colleagues (his ref 1), we have found that the combination of rigid and fibreoptic bronchoscopes provides greater versatility than the use of a rigid instrument alone: the Storz ventilating bronchoscope provides good airway control and excellent access for proximally situated tumours, while the fibreoptic bronchoscope is superior for treating more peripheral tumours.

The duration of our treatments is very variable and depends on the amount of tumour within the tracheobronchial tree; treatments of two to three hours are exceptional. Mr Moghissi implies in his letter that, although his treatments last no longer than 35 minutes, more than one session may be given within a short interval. We prefer to complete treatment in one session as this minimises the overall discomfort and inconvenience to the patient. We also believe that it is important to clear as much tumour as possible from the airway in a single session as this will protect the airway from the hazards of postoperative exudation and oedema.

Clearance of exudate and resolution of oedema may account for the continued improvement in lung function which occurs during the postoperative period. In the study under discussion we performed lung function tests three to five days after treatment, and so it is possible that our results underestimated the magnitude of improvement. Unlike Mr Moghissi, however, we have found that improvements in peak expiratory flow are usually evident immediately after treatment. If we had limited our treatment sessions to 35 minutes such improvements might not have been obtained.

We agree that the duration of hospital admission is determined by both logistical and medical factors. Most of our patients (about three quarters) live outside the districts of our two hospitals and this inevitably lengthens their stay in hospital. An appreciable number are also in need of inpatient hospital care at the time of referral; many have infection distal to the obstructing tumour and some are close to asphyxiation.[1] The average hospital stay of 7·8 days that we reported in our paper does not seem unreasonable in such circumstances.

Clearly, conclusions on the relative merits of different bronchoscopic techniques cannot be based on a comparison of data obtained in unmatched groups of patients. Although objective assessments of these different techniques would be desirable, the final choice will surely remain a matter of taste for the individual.

PJM GEORGE
MR HETZEL
FJC MILLARD
University College Hospital
and St James's Hospital, London

1 George PJM, Garrett CPO, Hetzel MR. Role of the neodymium YAG laser in the management of tracheal tumours. *Thorax* 1987;**42**:440–4.

Notice

Symposium in the practical management of patients with cystic fibrosis

A symposium entitled "Growing Points in the Practical Management of Cystic Fibrosis Patients" will be held on Friday 22 April 1988 at East Birmingham Hospital Postgraduate Medical Centre. Full details from Miss M C Wood, postgraduate secretary, East Birmingham Hospital, Birmingham B9 5ST (021 772 4311).

See also notices on p. 217.