Dear Editor,

I have read the manuscript entitled “Soft Tissue Sarcoma Metastatic to Pleura” by Yildirim et al. (1) published between the pages 197-200 in Journal of Tuberculosis and Thorax, issue number 56(2) of 2008. I should, firstly, congratulate the authors. Indeed, I want to point out some remarks about this manuscript.

1. There is a history of pleurodesis that did not yield a successful result during the course of the patient’s treatment. However, I believe pleurodesis should not have been carried out in this patient. Malignant pleural effusion (MPE) is a common complication of advanced cancer. The presence of MPE eliminates the possibility of radical cancer treatment, but palliative care plays an important role for these patients. Chemical pleurodesis is one of the options to avoid development of recurrent pleural effusions and thus palliate symptoms (2). In order pleurodesis to be successful, MPE should be drained by serial thoracentesis or chest tube insertion to achieve complete lung re-expansion. Regardless of the volume of pleural space drainage, pleurodesis should be carried out as soon as the condition is diagnosed by chest roentgenogram because inflammation induced by pleurodesis would cause the parietal and visceral layers of the pleura to adhere, and the space would disappear, only when they come into close contact with each other. Sahn argued that patients are suitable candidates for pleurodesis if and when expected survival is at least several months, the patient is not debilitated, and the pleural fluid pH is ≥ 7.30. The author has also argued that pleural fluid pH < 7.30 not only suggests a short survival-time but also predicts a poor response to chemical pleurodesis (3). Moreover, fibrosis involving the pleural surfaces in the low-pH effusions diminishes the effectiveness of pleurodesis in producing pleural symphysis (4). In this case, the pleural fluid pH was 7.05 and complete apposition of the pleural surfaces had not been achieved despite fibrinolytic treatment. Therefore, the chance that this patient will benefit from pleurodesis is very little, if any.

2. The agent used during pleurodesis was not specified and there is a risk of deterioration in the clinical progress of the patient due to the complications of pleurodesis. A number of antineoplastic and non-antineoplastic chemical agents have been used for pleurodesis. Currently, the most successful and widely-used agents include talc, the tetracyclines, and bleomycin (3,5). In addition to these, erythromycin, minocycline, methylprednisolone acetate, cisplatin, cytarabine, doxorubicin, etoposide, fluorouracil, interferon-β, and mitomycin-C have been used rarely during pleurodesis (6). Pleurodesis is not an entirely benign procedure due to various side effects and serious complications caused by these agents. These range from mild and generally temporary complications and side effects such as pain, fever, nausea, vomiting, diarrhea, vertigo, dizziness, and uncomfortable feeling to more serious complications requiring complicated treatments such as atrial arrhythmia, respiratory failure, pulmonary oedema, adult respiratory
distress syndrome, pneumonitis, empyema, pulmonary fibrosis, bone marrow suppression, renal toxicity (6). The negative effects of these complications on the quality of life is a serious issue, considering that survival may be as short as several months in these patients and, therefore, pleurodesis needs to be performed when it is definitely indicated.

Best regards.

REFERENCES

Yanıt
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From the authors
We greatly appreciate the comments on our paper. Previous studies have shown that a low pleural fluid pH correlates with the extent of intrapleural tumour burden and that various physiological variables, such as pleural fluid pH, may be indicative of the outcome of pleurodesis (1). Firstly, we do not believe that pleural fluid pH < 7.30 is a contraindication for pleurodesis, but only predictor of success. Aelony demonstrated a very high rate of successful pleurodesis in patients suffering from recurrent malignant pleural effusions with low pleural pH (2). Heffner et al. reported, in a recent meta-analysis, that pleural fluid pH has only modest value for predicting symptomatic failure, and should be used with caution when selecting patients for pleurodesis (3). We agree that there was a little chance for successful pleurodesis because complete apposition of pleural surfaces can not be achieved. Nevertheless, it is difficult to accurately determine the predictors of successful pleurodesis.

Secondly, we used 4 g steril talc for pleurodesis. In clinical practice, pleurodesis with various sclerosing agents is a simple and acceptable procedure with high efficacy for controlling malignant pleural effusions. Several studies have shown that talc, whether by poudrage or slurry, is the most effective pleurodesis agent available. However, there are serious concerns about its safety. For this patient, there were no side effects or complications attributable to the procedure. The cause of death is related to the advanced nature of the patient’s underlying disease, but not side effects of pleurodesis.

We thank reader for their remarks and suggestions.

REFERENCES