population studied was extremely heterogeneous, both with regard to type of operation and route of access, with laparoscopies and laparotomies considered together. The patients were at intermediate risk of PPC (based on a 10% incidence of PPC); to maximally demonstrate a reduction in PPC, it would have been prudent to selectively study those at the highest risk. Using an end point of the incidence of unspecified PPC is imperfect because the different PPC are not of equal clinical significance: atelectasis is less significant than pneumonia or respiratory failure. The choice of physiological variables was unusual, and it would be interesting for the authors to comment on their choice of measures and why alternatives (eg, cough peak flow, maximum expiratory pressure, sniff nasal inspiratory pressure) were not studied. Finally, external validity may be limited because the described routine management is divergent from what we consider standard practice; namely, the absence of use of epidural anesthesia.

The conclusions are overstated. First, although LETs may not have altered thoracoabdominal mechanics as measured by these devices, this finding does not mean that alternative measures might not be altered (perhaps measures that relate more closely to PPC). Most importantly, the assertion that the LETs do not prevent PPC is not supported by the data. This claim is possibly a type II error due to inadequate sample size. The effect of LETs on PPC is important and warrants an adequately powered study with a sufficiently homogeneous population who are at high risk of PPC.

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References


Controversies After Brain Death

When Families Ask for More

To the Editor:

Luce1 described the case of Jahi McMath, a teenager whose family requested organ support be continued after she was declared brain dead, citing religious objection to death by neurologic criteria. Only four states (California, Illinois, New Jersey, New York) have laws about how to handle religious objection to brain death. Whereas New Jersey’s statute is very clear about how to manage situations like the McMath case, the laws in the other three states are vague (Table 1).2-5 Thus, there is no concrete guidance for physicians in 98% of the country (49 states) about how to behave in situations like the McMath case.

Should a brain death evaluation be performed in spite of a family’s objection to determination of death by neurologic criteria? Once an evaluation has been performed and a patient is determined to be brain dead, is family permission necessary to discontinue organ support? If support is continued, should vasopressors, hormones, or antibiotics be started if clinically indicated? Should a do-not-resuscitate order automatically be issued, or should the family be allowed to determine code status? Should the patient be kept in an intensive care unit or transferred to a regular floor or long-term care facility? Should a time frame for discontinuation of support be mandated, or should support be continued until the patient exhibits a terminal cardiac rhythm? If support is continued until the patient becomes asystolic, should the death certificate reflect the time of death by neurologic criteria or the time of asystole? Who should be fiscally responsible for the patient’s care after brain death determination?

These controversies are particularly challenging because they produce emotional distress for both the family and the medical team at a time that is already wrought with raw emotion. The ethical responsibilities of physicians facing these circumstances are gray given the competing desires to (1) respect families, (2) maintain a patient’s dignity, and (3) optimize intensive care resources and health-care dollars. Furthermore, physicians may fear
repercussions of ignoring a family’s wishes, such as legal action, negative publicity, or job loss.

Because solving these controversies is a formidable task for individuals or institutions, we recommend the creation of guidelines on management of these complex situations. Additionally, families may request continuation of organ support after brain death because of nonacceptance of death or the desire to await arrival of other family members, so physicians also need guidance to manage these scenarios.

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TABLE 1 | Accommodation Laws by State

<table>
<thead>
<tr>
<th>State</th>
<th>Law</th>
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<tbody>
<tr>
<td>California²</td>
<td>“If the patient’s legally recognized health care decision-maker, family, or next of kin voices any special religious or cultural practices and concerns of the patient or the patient’s family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns.”</td>
</tr>
<tr>
<td>Illinois³</td>
<td>“Every hospital must adopt policies and procedures to allow health care professionals, in documenting a patient’s time of death at the hospital, to take into account the patient’s religious beliefs concerning the patient’s time of death.”</td>
</tr>
<tr>
<td>New Jersey⁴</td>
<td>“Hospitals should establish written procedures for the acknowledgement of the patient’s religious beliefs, if the examining physician has reason to believe, on the basis of information in the patient’s available medical records, or information provided by a member of the patient’s family or any other person knowledgeable about the patient’s personal religious beliefs, that such a declaration of death by neurological criteria would violate the personal religious beliefs of the patient. In these cases, death shall be declared, and the time of death fixed, solely upon the basis of cardio-respiratory criteria.”</td>
</tr>
<tr>
<td>New York⁵</td>
<td>“Hospitals must establish written procedures for the reasonable accommodation of the individual’s religious or moral objections to use of the brain death standard to determine death when such an objection has been expressed by the patient prior to the loss of decision-making capacity, or by the surrogate decision-maker. Policies may include specific accommodations, such as the continuation of artificial respiration under certain circumstances, as well as guidance on limits to the duration of accommodation.”</td>
</tr>
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References

Bronchial Thermoplasty
Misleading Differences in Asthma Exacerbation Rates!

To the Editor:

I read with interest the reply of the AIR2 trial authors entitled “Bronchial thermoplasty: ready for prime time—evidence is there!”1 One of the major findings in the AIR2 trial reported by Castro et al2 was the statistically significant difference in the rate of severe asthma exacerbations per subject per year between the bronchial thermoplasty arm and the sham arm. It is important to observe that the two groups were not matched in their baseline exacerbation rate per subject per year (see Table 1 in the AIR2 trial). Therefore, the difference in the asthma