Correspondence


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Reply to Mahler

From the Authors:

We appreciate Mahler’s correspondence related to our research statement (1), the goal of which was to identify knowledge gaps that future research studies can address to efficiently translate biomarkers into clinical practice. To reach this goal, we chose to focus on example biomarkers for select lung diseases rather than create a comprehensive list of all biomarkers for all pulmonary diseases. As stated in the article, “the biomarkers discussed in this research statement are not intended to be comprehensive.” Thus, we did not state or intend to imply that fibrinogen is the “sole” biomarker in chronic obstructive pulmonary disease (COPD). We agree with Mahler that the peak inspiratory flow rate is a promising COPD biomarker, and encourage studies of this and other promising biomarkers for COPD and other lung diseases.

Author disclosures are available with the text of this letter at www.atsjournals.org.

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Reference


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Long-Term Outcomes after Prolonged Mechanical Ventilation: What of Those Cast Away?

To the Editor:

We read with interest Jubran and colleagues’ article titled “Long-term outcome after prolonged mechanical ventilation: a long-term acute-care hospital study” (1). As critical-care survivorship increases, we will increasingly need to confront the issue of whether interventions made in extremis result in outcomes consistent with the long-term wishes of patients. Jubran and colleagues’ findings that more than half of the patients in their study were detached from a ventilator by discharge from a long-term acute-care hospital, and that 85% of survivors of prolonged mechanical ventilation would choose to again undergo prolonged ventilation could potentially inform decision-making regarding prolonged mechanical ventilation. However, to apply the findings of Jubran and colleagues to patient care, it is necessary to understand the selection process by which patients were enrolled in the clinical trial on which the study was based (2).

Our interpretation of the original randomized trial’s Consolidated Standards of Reporting Trials flow diagram is that 2,267 patients were screened and 316 were enrolled, and these 316 patients represent the cohort included in the current secondary observational analysis. Acknowledging the challenges of enrolling patients with prolonged mechanical ventilation in a randomized trial, we note that most patients were excluded from the trial owing to an inability or refusal to consent, and many others were excluded owing to profound neurologic deficits or a life expectancy of <3 months. We wonder if the exclusion of most long-term acute-care hospital patients—the 316 patients enrolled reflect less than 14% of the originally screened sample—introduced substantial selection bias into the estimates of ventilator liberation and patient satisfaction. We speculate that the excluded patients had disease characteristics (including an inability to participate in handgrip, maximum inspiratory pressure maneuvers, or quality-of-life and preference questionnaires) that would decrease the total proportion of patients detached from the ventilator, leading to different conclusions. Could the authors expand upon how their results should be interpreted in light of the narrow selection criteria that led patients to participate in the original trial?

Finally, we noted also that the authors invoked Daniel Kahneman’s “experiencing self” and “remembering self” in the context of 85% of survivors being “willing to [again] undergo a further episode of prolonged ventilation.” We wish to note that only survivors—and only those with an intact mental status, at that—are afforded the opportunity to convey a remembering self. It is impossible to ask either decedents or survivors without an intact

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