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Response

To the Editor:

We appreciate Dr Argulian's interest in our recent article in *CHEST*¹ (September 2012) about the association between circulating cardiac troponin T levels measured by a high-sensitivity assay (hs-cTnT) and the prevalence of obstructive sleep apnea (OSA) in a sample derived from the general population oversampled for subjects at high risk of OSA. Dr Argulian observes that the prevalence of detectable hs-cTnT was 43% and compares this value to other US general population-based samples. Because hs-cTnT values are known to be strongly associated with age in population-based samples and the subjects included in our study were relatively young (mean age, 48.4 years),¹ it seems most relevant to compare the values we obtained with those observed in similar age segments in other studies. As pointed out by Dr Argulian, the prevalence in participants aged 40 to 50 years in the Dallas Heart Study was 24%,² that is, significantly lower than the overall prevalence found in our study. However, the prevalence of detectable hs-cTnT in subjects without OSA in our study was 30%, which is not very different from the values observed in the Dallas Heart Study.

We documented a univariate dose-response relationship between severity of OSA and hs-cTnT levels. Dr Argulian further suggests investigating the association between the top quartile of hs-cTnT and the severity of OSA. Based on this suggestion, we substituted our dependent variable (detectable hs-cTnT > 3 ng/L) with the top quartile (> 5.61 ng/L). By logistic regression analysis, an apnea-hypopnea index of 5 to 29.9 was associated with an OR of 1.86 (95% CI, 1.17-2.98) for hs-cTnT in the top quartile, and an apnea-hypopnea index of ≥ 30 was associated with an OR of 4.47 (95% CI, 2.50-7.90). However, in a multivariate model, OSA did not emerge as an independent predictor of hs-cTnT in the upper quartile in this population-based cohort, confirming the conclusion drawn in our original report.

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Consider Talc Too in Poorly Controlled Asthma and Unexplained Bronchiolitis

To the Editor:

The case report of talc endobronchitis highlighted by Ong and Takano¹ in an issue of *CHEST* (August 2012) is a useful reminder of a different mode of presentation of talc-related lung disease. They highlighted the four more common syndromes, but it is worth noting that talc-related lung disease should also be considered in the differential of unexplained bronchiolitis or poorly controlled asthma, as previously reported.² In this case, the patient had documented asthma not responding to treatment, with evidence of unexplained bronchiolitis on cross-sectional imaging and no other explanation on intensive investigation. The surgical lung biopsy specimen confirmed the diagnosis of talc-related nodular granulomatous infiltrates with a peribronchiolar distribution as well as a perivascular fibrosis, and subsequent occupational history confirmed probable talc exposure through work as a dental technician. (French talc was used to produce a high luster on plaster models of teeth in the past.)

In summary, it is worth considering talc-related lung disease in poorly controlled asthma or unexplained bronchiolitis in addition to severe endobronchitis and the other more common syndromes summarized by Ong and Takano.¹ As ever, a corroborative occupational history is key.

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Premature Termination of Life Is Not Palliative Care

To the Editor:

Attorney Kathryn Tucker's¹ guidance in an issue of *CHEST* (July 2012) for physician aid in dying is troubling. A citation error was apparent in a reference to the Expert Consensus Statement of the Heart Rhythm Society (HRS) regarding withdrawal of cardiovascular implantable electronic devices (CIEDs).² Tucker¹ wrote, "Provision of aid in dying does not constitute assisting a suicide or euthanasia." The HRS statement reads, "Ethically, CIED deactivation is neither physician-assisted suicide nor euthanasia."²

CIED deactivation is not aid in dying, and the HRS statement said why: "The clinician's intent is to discontinue the unwanted treatment and allow the patient to die naturally of the underlying disease - not to terminate the patient's life."² This reaffirms a half century of understanding in medical ethics that withdrawal of undesired care is just that and not aid in dying.

Per Tucker,¹ "Principles of autonomy that underlie respecting patient rights...to request pain medication even if it advances time of death support the choice for aid in dying." Providing medication doses that might hasten death is not equivalent to giving them because they will do so. Even autonomy has its limits.

Tucker¹ again appears to misapply the HRS CIED statement, "A clinician cannot be compelled to provide treatment that conflicts with his or her personal values. In these circumstances, the clinician cannot abandon the patient but should refer the patient to a colleague who is willing to provide the service."¹ The issue was CIED removal. Refusal to aid a suicide request is not abandonment, and referral for it is morally equivalent to providing the aid in dying. Requiring it violates three federal statutes protecting conscience rights.

Tucker¹ asserted, "Modern medicine can extend the dying process so long that some terminally ill patients may find the process unbearable." The reality of aid in dying scenarios is rarely this dramatic, and exceptional cases make for bad guidelines. The claim of unbearable process refutes futile care rather than arguing for

aid in dying, and futile care is preventable under existing guidelines by patients and their surrogates without violating any profession, legal, or moral precepts.

Compassion means to come along side and suffer with, not to aid patients in self cessation. Terminal patients have well-defined needs: Treat depression, loneliness, and pain, and death wishes abate. Palliative care and aid in dying are at odds: A clinician cannot be both patient advocate and assistant in dying. The conflict of interest is insurmountable.

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Response

To the Editor:

Dr Van Mol misunderstands the reference to the consensus statement regarding deactivation of cardiovascular implantable electronic devices in my recent article in *CHEST*.¹ The statement is cited not to suggest device deactivation is aid in dying, but as an example of how medical practice in an evolving arena benefits when such a statement or clinical practice guidelines are promulgated, offering guidance on an emerging practice. It is timely for guidelines to emerge regarding the practice of aid in dying, which has been openly available for 15 years in Oregon and more recently in Washington, Montana, and Hawaii. It is likely to become more widely available nationwide as the consensus grows that the option harms no one, galvanizes improved communication and care for all terminally ill patients, and offers a peaceful death to the relatively few patients who choose it. The consensus is based on evidence. Health professionals who embrace evidence-based medicine, including the American Public Health Association, have carefully examined evidence from Oregon and have concluded that the availability of aid in dying poses no danger and offers a desired choice for some patients; accordingly, the association adopted policy supportive of aid in dying.² Other national medical organizations have also done so.³ Physicians willing to provide this compassionate option to patients experiencing a dying process they find unbearable, despite excellent pain and