anticoagulation with mechanical valve replacement, should be balanced against the risk of proximal reoperation during follow-up. Regarding the published experiences of centers favoring aortic root preservation in the setting of acute type A dissection, it has been our institution's policy to consider more definitive aortic root repair for patients presenting with dissection of all sinuses, an aortic root diameter >47 mm, or dissection extending to the iliac arteries.²⁻⁴

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FIBROSING INTERSTITIAL PNEUMONIA: IS MECHANICAL VENTILATION ALWAYS THE FINAL ALTERNATIVE FOR THE INTENSIVIST?

To the Editor:

Currently, invasive mechanical ventilation (IMV) in patients with fibrosing interstitial pneumonia is a devastating situation in the intensive care unit (ICU). After 2 decades, the prognosis is still poor.

Gaudry and colleagues,¹ in an original retrospective multicenter French study, describe short- and long-term

outcomes in critically patients with fibrotic lung diseases undergoing IMV. In their view, more frequent use of lung protective strategies may influence poor outcomes, and individual evaluation case-by-case evaluation is needed for appropriate discrimination of ICU patients. Their arguments are solid, rational, and comprehensive for current practice and across all published studies, although major drawbacks of this study were its retrospective design and limited number of patients. Obviously, the recommendations are reasonable and appropriate; however, some points need to be taken into account:

First, the authors did not describe reasons for underuse of lower-level aggressive ventilation alternatives before IMV in these populations. Were the use of noninvasive ventilation and criteria for IMV in this study reflected properly? Recently, new and promising observations have emerged: (1) Although there is still only a small number of studies, early use of noninvasive ventilation in selected patients may avoid IMV and improve clinical conditions at ICU admission.² (2) Nasal high-flow cannulation may improve oxygenation in concert with low positive end-expiratory pressure in selected patients. Some patients with pulmonary fibrosis have been treated under expanded indications for nasal high-flow cannulation with promising results.³

Second, it is interesting that patients who met criteria for lung transplant and were breathing spontaneously with noninvasive ventilation have shown the best outcome as bridge to lung transplant and adequate results after bilateral lung transplant.⁴ These are promising alternatives to IMV for selected patients.²⁻⁴

Third, lung-protective ventilation arguably provides the best hope for good results of IMV in these patients. It is a reasonable hope; however, lung damage is currently equally associated with high levels of inspiratory oxygenation fraction and low tidal

volume with high or normal positive end-expiratory pressure.⁵ Although large, prospective studies are nonexistent, it is a promising avenue.

Finally, it would be interesting to know details regarding survivors that are lacking in these studies, such as measurements of health-related quality of life, and the influence of specific natural history, such as rates of hospital admission and exacerbations after ICU discharge and impact of early pulmonary rehabilitative programs.

Further large international database studies will illuminate solid bases to define risk factors and prognosis in these directions.

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Reply to the Editor:

We thank Dr Esquinas for his comments and interest in our work.¹ First, we would like to underline that our goal was not to promote invasive mechanical ventilation (IMV) for patients with end-stage fibrosing interstitial pneumonia but rather to provide an update on their prognosis. Obviously,