20 seconds) that it would appear they could hardly be speeded up much in their action by chewing.

We, too, have noted the acceleration of the pulse rate during steady-state walking, but it would be difficult to pinpoint a time of onset for this side effect in an already accelerated heart rate. Since we were primarily interested in the effect on anginal pain, we were particularly alert to changes in this symptom. We did make note of the effect on the electrocardiogram and the blood pressure and found that the pressure was the primary determinant of the so-called double product (heart rate \times\text{ systolic blood pressure}).

\textbf{Statement from ACCP Committee on Pulmonary Rehabilitation}

\textit{To the Editor:}

The following statement has been approved by the Committee on Pulmonary Rehabilitation of the American College of Chest Physicians:

Home oxygen is a safe form of therapy. This has been proven by its use in chronic obstructive pulmonary disease patients with proper instruction in standard safety measures.

\textit{Thomas L. Petty, M.D., F.C.C.P.}
\textit{Chairman, Committee on Pulmonary Rehabilitation}
\textit{Denver}

\textbf{Propranolol Therapy and the Q-T Interval}

\textit{To the Editor:}

Crawford and co-workers\textsuperscript{1} have reported in \textit{Chest} on the successful treatment with combined ventricular pacing and propranolol of a patient with the syndrome of a prolonged Q-T interval. These investigators stressed that propranolol usually acts favorably in such patients, as also reported by previous investigators.\textsuperscript{2-5} while drugs such as quinidine and procaineamide should not be employed, because they prolong the Q-T interval. Crawford and co-workers accept that propranolol is considered to be the most effective drug for preventing the ventricular arrhythmias in this syndrome, but they believe that the effect of this drug on the Q-T interval is "inconsistent" and conclude that the precise mechanism of the beneficial effect of this drug in the syndrome of prolonged Q-T interval is unclear.

May I draw your attention to a previous investigation published in 1969,\textsuperscript{6} describing the effect of intravenously administered propranolol hydrochloride on the electrocardiograms of 21 normal subjects? In all but one examinee, this study demonstrated a shortening of the Q-T under the effect of this drug. This observation may explain the beneficial effect of propranolol therapy in patients who have a congenitally prolonged Q-T interval. It would be interesting to investigate the effect of this drug on the Q-T interval in a large series of such patients, a study not yet performed, to the best of my knowledge.

\textbf{References}


\textbf{Bone Resorption in Progressive Systemic Sclerosis}

\textit{To the Editor:}

In the December 1975 issue (\textit{Chest} 68:838-840, 1975), an article entitled "Bone Resorption of the Ribs and Pulmonary Function in Progressive Systemic Sclerosis" by Steigerwald et al was published. It stated that "Heretofore, however, there have not been, to our knowledge, any reports of bone resorption of the ribs in PSS" (progressive systemic sclerosis).

The authors have completely misstated the facts! Reference is made to an article entitled "Superior Marginal Rib Defects" by E. Nicholas Sargent, M.D., Franklin Turner, M.D., and George Jacobson, M.D., which was published in the July 1969 issue of the \textit{American Journal of Roentgenology} (106:491-505, 1969). In this article, examples of progressive systemic sclerosis including photographs of rib destruction are presented, and an additional reference by Keats is quoted.

It is obvious that the authors have made a very poor search of the literature, and their case presentation certainly is not the first in the literature!

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