We do not agree that all patients with “initial” stage III M₁ disease established by clinical criteria alone have metastatic disease. Furthermore, metastatic disease must be taken to exclude the possibility of a second disease. In such cases, radiographic and isotope studies can be very helpful.

We remain in strong support of adequate staging of patients with bronchogenic carcinoma and support the use of radioceliotate scans to verify suspected metastatic lesions and to evaluate any patient with a clinical indication of metastatic disease. We are distressed at physicians taking a step away from the patient and towards more procedures. We are confident that the evidence still states clearly that patients with normal history, physical examination and routine laboratory studies need not be staged further by pre-surgical methods.

Robert G. Hooper, M.D., F.C.C.P.,
St. Luke’s Center for Pulmonary Excellence, Phoenix, and
Cash R. Beechler, M.D., F.C.C.P.,
Maricopa County Hospital, Phoenix

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To the Editor:

Our study referred to by Drs. Hooper and Beechler was completed in June, 1977. It attempted to provide a sequential approach to the staging of the lung cancer patients. Further analysis of our results with gallium scanning (DeMeester et al, Am Thorac Surg; 1979 28:451-464) confirmed that a 75 percent gallium sensitivity rate was obtained for metastatic disease revealed by other scans. In addition, gallium scanning identified 11 of 12 patients with occult disease. We feel that the value of gallium scanning should not be limited only to the patient with clinical evidence of metastatic disease with otherwise negative specific organ isotope studies, as suggested by Drs. Hooper and Beechler, but rather it should be used to screen patients with no symptoms of metastatic disease, as well as a parameter to follow the response to chemotherapy in patients with metastatic disease. In confirmation with the thoughts of Drs. Hooper and Beechler, we too feel there should not be a step away from the patient toward more procedures. Thus, since November, 1977, the only scans we do initially is a gallium. If there is a clinical finding which is not supported by the findings on gallium scan or if there is a suspicious area in the gallium scan, then a specific organ or x-ray film is ordered for comparison and possible confirmation. If necessary, open biopsy is performed to resolve indeterminate findings. If the biopsy is positive, it provides tissue for tumor cell type and confirmation of M₁ disease. In this situation, no further workup is necessary and therapy can begin. With this approach, we find that the goals of sequential staging can still be a reality, yet the direction and cost of staging can be lessened.
Lack of Effect of Erythromycin on Theophylline Serum Levels

To the Editor:

In a recent editorial by Van Dellen (Chest 1979; 78:2-3) discussing the use of intravenous aminophylline, the author states that “... the half life (of theophylline) is prolonged in cases of ingestion of theophylline.” While the inhibition of theophylline clearance by theophylline is well documented,1 the effect of erythromycin on theophylline plasma levels is not well defined.

Although some reports have pointed to an increased theophylline plasma level in children with concomitant erythromycin administration,2,3 a recent study of adult subjects by Pfeifer et al4 found no consistent evidence of a kinetic interaction between orally administered erythromycin and intravenous theophylline. Additionally, in an as yet unpublished study from our laboratory we found no statistically significant effect of oral erythromycin on theophylline plasma levels in eight normal adult volunteers. Therefore, our preliminary data are not consistent with those of earlier studies, and warrant further examination of the clinical and scientific significance of the potential drug interaction of erythromycin and theophylline.

It would appear that the effect, if any, of erythromycin on theophylline serum levels has yet to be determined.

Susan K. Pingleton, M.D., F.C.C.P.; Stephen J. Kelly, B.A.; and Patrick B. Ryan, Pharm.D.
University of Missouri School of Medicine, Kansas City, Missouri

REFERENCES


Persistent Contamination of the Flexible Fiberbronchoscope following Disinfection in Aqueous Gluteraldehyde

To the Editor:

In 1975, Webb and Vall-Spinosa (Chest 88:703-708, 1975) reported an outbreak of *Serratia marcescens* associated with the flexible fiberbronchoscope. The persistence of *Serratia* in the bronchoscope was attributed to an ineffective cleaning technique. Adoption of a revised procedure ended the outbreak, and no further infections related to bronchoscopy were identified.

At The New York Hospital Burn Center, we recently recovered strains of *Serratia marcescens, Klebsiella pneumoniae*, and *Pseudomonas aeruginosa* from an Olympus fiberoptic bronchoscope after cleaning both according to a method similar to the revised Webb and Vall-Spinosa procedure and the Olympus instructions, including disinfection for 30 minutes in gluteraldehyde (Cidex). Only after an additional 45 minutes in gluteraldehyde did we eliminate the organisms.

Since we obtained the Olympus bronchoscope in 1977, the cleaning procedure has included successive aspiration of 20 percent povidone iodine scrub solution, 50 percent alcohol, and sterile water through the biopsy channel, with air drying by suctioning unfiltered ambient air. After several cultures of the sterile water aspirate were negative for pathogens, routine culturing of the bronchoscope was eliminated.

In December, 1978, the bronchoscope was used on a severely burned patient who had *Serratia marcescens, Klebsiella pneumoniae*, and *Pseudomonas aeruginosa* in her sputum and was subsequently cleaned according to the procedure described above. At the time of the bronchoscopic procedure, she was the only patient on the unit with *Serratia* sensitive to gentamicin and amikacin, all other *Serratias* being resistant to all antibiotics.

One week after use, sterile water was aspirated through the biopsy channel of the bronchoscope and on culture yielded heavy growth of the same organisms with the same sensitivity patterns as the patient’s. The bronchoscope was recleansed and disinfected according to recently released manufacturer’s instructions. These included: