reversibility determined? Were the two groups comparable in age, duration of illness, smoking history, corticosteroid therapy? How "stable" was their disease? 2) How was the random assignment made? 3) How was the IPPB given? Was it determined that each group received the volume (dose) of nebulized agent that was intended? 4) How were the pulmonary function tests performed—a single exhalation, the best of three "blows"? In what order were the tests performed? A single full inhalation will in itself induce bronchoconstriction. What equipment was used? 4) Why is the heart rate not given? 5) How is the "overall difference" calculated?

I think that there are important flaws in this study and that the authors need to provide the reader with more information before their data can be interpreted.

**Philip C. Hopewell, M.D.**

**Associate Professor of Medicine,**

**University of California, San Francisco**

To the Editor:

Although a crossover study would have been preferable, practical considerations prevented use of such a study; many of the patients were too ill to be withdrawn from their bronchodilator medications for long periods of time. Baseline data were not included in the report for the sake of brevity. The metaproterenol and isothiourine/phenylephrine groups were equivalent in terms of age, sex, baseline vital capacity and severity of airway obstruction, as shown in Tables 1 and 2.

**Table 1—Patient Characteristics By Treatment Groups**

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Metaproterenol Solution (N = 14)</th>
<th>Isothiourine Solution (N = 13)</th>
<th>Test of Significance</th>
<th>P-Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex:</td>
<td>4</td>
<td>6</td>
<td>0.58*</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity of Disease:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>5</td>
<td>6</td>
<td>0.82</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>7</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Age (±SEM)†</td>
<td>34.8(±5.05)</td>
<td>38.7(±4.95)</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>34.8(±5.05)</td>
<td>38.7(±4.95)</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>44.1(±5.25)</td>
<td>45.9(±6.95)</td>
<td>0.83</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>41.4(±4.09)</td>
<td>42.5(±4.44)</td>
<td>0.82</td>
<td></td>
</tr>
</tbody>
</table>

*P-values for the test of homogeneity of two groups.†(standard error of the mean)

**Table 2—Pre-treatment Mean Pulmonary Function Test Results By Treatment Groups**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Metaproterenol Solution (N = 14)</th>
<th>Isothiourine Solution (N = 13)</th>
<th>Test of Significance</th>
<th>P-Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEV1</td>
<td>1.685(±0.248)*</td>
<td>1.864(±0.295)</td>
<td>0.64</td>
<td></td>
</tr>
<tr>
<td>FEF25-75%</td>
<td>1.034(±0.251)</td>
<td>1.026(±0.260)</td>
<td>0.98</td>
<td></td>
</tr>
<tr>
<td>FVC</td>
<td>2.876(±0.343)</td>
<td>3.312(±0.344)</td>
<td>0.38</td>
<td></td>
</tr>
</tbody>
</table>

*(± standard error of the mean)

We feel that the conclusions of the study are justified even though the study design, of necessity, was not ideal. The bronchodilators were administered by IPPB because this was the treatment of choice at our institution when the study was initiated and isothiourine/phenylephrine was the standard agent used. We now use primarily aerosol therapy and have been using a solution which contains isothiourine alone.

**Jeffrey B. Riker, M.D., F.C.C.P.**

**Medical Director, Respiratory Care Services, Memorial Hospital Medical Center, Long Beach**

**Correction: The Appeal Process in British Columbia**

To the Editor:

I wish to correct a statement made on page 382 of the August, 1980 issue of Chest referring to the appeal process in British Columbia.

In British Columbia the claimant nominates one specialist, the employer nominates the second specialist and the Minister of Labour appoints a Chairman of the three-person committee. All of these appointments come from a list prepared by the College of Physicians and Surgeons and supplied through the Minister of Labour's Office.

**G. McMillan, Director, Information Services**

**Department, Workers' Compensation Board of British Columbia, Vancouver**

"Coin Lesion" Asthma

To the Editor:

Recently I have encountered a clinical problem that may be instructive to other pulmonologists and allergists.

**Case Report**

A 43-year-old man with a long history of asthma presented with sudden onset of extreme shortness of breath. He had complained of his usual very mild wheezing in mid-morning. He took an inhalation from the isothiourine inhaler he keeps in his pants pocket. His dramatic increase in symptoms began immediately thereafter.

On examination, his respiratory rate was 32 per minute. There was marked hyperinflation of the right chest with a shift of the trachea to the left. Decreased breath sounds were present on the right. Mild wheezing was present on the left. Chest x-ray film demonstrated a metallic foreign body (Fig 1).

Fiberoptic bronchoscopic examination was performed according to routine protocol. Just past the main carina was a nickel lying transversely across the right mainstem, its lateral edge lying in the right upper lobe bronchus. During inspiration, a narrow slit-like orifice on the medial edge allowed passage of air. This closed on expiration, account for the findings of "ball-valve" obstruction on examination and chest roentgenogram. A "crocodile" forceps was passed through the medial slit and withdrawn with the forceps partially opened. This flipped the nickel edge up and allowed for easy grasping and withdrawal. The patient's symptoms were immediately relieved.

**Discussion**

This problem almost repeated itself in another patient.

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Men commonly carry their inhaler in their pants pocket, women in their purses. For convenience, they store it in the "ready" position. The cap will not fit the mouthpiece end at the top (Bronkometer), allowing for coins (pennies, nickels, dimes) to lodge inside. The patient, during inhalation, inhales deeply with maximally opened vocal cords. It is the ideal situation to allow unobstructed passage into the airways. It may be well to warn patients of the possibility that foreign material may lodge in the mouthpiece. Perhaps it would be advisable for the drug companies to make both ends of the mouthpiece the same size (this is true of the metaproterenol [Alupent] inhaler). The patient could then keep the cap on and prevent access to the inside of the mouthpiece. Even then, however, the patient should be instructed to keep the cap on when storing the inhaler in his pocket.

Robert P. Stevens, M.D.
Section of Pulmonary Medicine, Wenatchee Valley Clinic, Wenatchee, Washington

Pulmonary Complications of Oral BCG

To the Editor:

During the past decade, the use of BCG as an adjuvant cancer therapy mode has increased markedly. The pulmonary sequelae of intraleral scarification technique of administration include granuloma formation and miliary diseases. 

Sweet 8 Few reports of the complications of therapy with oral BCG exist. Although interstitial pneumonia is described, to our knowledge a documented case of BCG air-space pneumonia has not been reported. Our patient illustrates the potential of oral BCG to produce such an illness.

CASE REPORT

A 58-year-old white man was begun on a course of monthly oral BCG therapy following left upper lobectomy for a well-differentiated bronchogenic adenocarcinoma. By the third month of the BCG regimen, skin testing with 5 TU resulted in 20 mm induration with blister formation. Cough, productive of white sputum, and left pleuritic pain began eight months postoperatively and one week after the last administered BCG. Chest x-ray examination (Fig 1) revealed a patchy, inhomogeneous consolidation in the left lower lobe. There was no resolution of symptoms with administration of ampicillin for a two-week period. Two sputum samples obtained four weeks after the last oral dose of BCG were positive on smear for acid-fast bacillus and subsequently grew a Mycobacterium species (3+4+ growth). Its culture characteristics were those of the BCG species; furthermore, both the patient's organism and the BCG organism used for his immunotherapy were of the same phage type. Following institution of isoniazid, ethambutol and rifampicin, there was complete clinical and radiologic resolution of the pneumonia over a two-month period.

DISCUSSION

The failure of resolution of the symptoms with ampicillin therapy and the time course of improvement (radiologically and clinically) with the antituberculosis medications, as well as the positive sputum cultures all support the diagnosis of BCG pneumonia. BCG pneumonia should enter into the differential diagnosis of air-space pneumonia in the patient receiving oral BCG immunotherapy.

Michael G. Sampson, M.D., and Niel C. Colman, M.D. Meakins Christie Laboratories, McGill University, Montreal

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