Disseminated Tuberculosis Caused by Mycobacterium intracellulare (Update)

To the Editor:

We read with interest our case report in the December issue of Chest (1982, 82:800-01), and reaffirmed in our own minds what a unique case this indeed was. However, since some discussion of the uniqueness of the case seemed in order, and, in fact, was apparently inadvertently omitted from the case report, we would like to offer the following.

Pulmonary infections caused by atypical mycobacteria have increased in recent years, while those due to Mycobacterium tuberculosis continue to decline. However, disseminated infection remains an extremely uncommon manifestation of disease due to atypical mycobacteria, usually occurring in immunocompromised patients with a mortality rate of approximately 75 percent. Our patient, as presented in our case report, had no evidence of malignancy and had not received steroids prior to her illness. This appears to be more characteristic of disseminated infection associated with M intracellulare. In his review, Wolinsky found that 20 of 30 patients with disseminated M intracellulare did not have an underlying illness.

The importance of the elevated antibody titer against Legionella pneumophila is not clear. Recently, a patient was described with concurrent Legionnaires' disease and active pulmonary tuberculosis indicating a possible association between the two diseases. In addition, studies have demonstrated cross-reactivity with significant elevation of Legionella titers in patients with certain other infections, as well as problems with standardization of the antigen for L pneumophila. While this may represent a nonspecific elevation of Legionella antibodies in our patient, the possibility remains of an antecedent infection with L pneumophila which predisposed our otherwise healthy patient to disseminated infection with M intracellulare.

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All opinions stated are those of the authors and not necessarily those of the United States Air Force.

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REFERENCES


Optimum Steroid Dosage in Status Asthmaticus

To the Editor:

Although corticosteroids are widely used in the treatment of status asthmaticus, an optimum dose has not been established. The study by Tanaka et al (Chest 1982; 82:438-40) did little to clarify this issue. As the authors noted, their study population was very small. Furthermore, the two groups were not identical, and the low dose group had a 25 percent higher baseline FEV1. Although no significant differences were present between the rest, PEF, pH, and Pco2 of the two groups, no statistical comparison of the FEV1 of the groups was offered. The reader must infer that they were significantly different. This lower baseline status of the high dose group may have obscured any additional benefits of the higher steroid dose.

The studies cited by the authors in support of their findings are similarly flawed. The use of three different compounds administered by two different routes obscures any interpretation of the study by Britton et al. In the study by Harfi et al, peak expiratory flow rate (PEFR) was the sole spirometric parameter followed, and substantial differences in the baseline PEFR of the two groups were present.

Unfortunately, the optimum dose of corticosteroids in status asthmaticus remains undefined. Larger study groups which are more closely matched will be required to settle this issue.

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REFERENCES


Antitussive Effect of Guaiifenesin

To the Editor:

In documenting how cough-counting has overcome earlier instrumental limitations, Kuhn and associates (Chest 1982; 82:713-18) have reaffirmed the poor correlation between this measurement and symptom estimates. While cough frequency is a reproducible objective index, it may not be the most appropriate to sense...