striking change in zone size between the two isolates could not be safely interpreted as a change from a susceptible to a resistant MIC.

The data on erythromycin susceptibility by Wallace et al. were incorrectly presented by Martin and Dall. Instead of eight of 14 strains of M fortui a being susceptible to 2 μg/ml, they (Wallace et al) reported only eight of 56 isolates (14 percent) to be susceptible to this test concentration. In a more recent study, only one of 96 isolates of M fortui (2.1 percent) was susceptible to 4 μg/ml of erythromycin (compared to 47 of 132 [36 percent] of Mycobacterium chelonei), suggesting little if any potential for use of this agent against isolates of M fortui.

In our experience in the treatment of nonpulmonary disease due to M fortui and M chelonei, drug resistance confirmed by MIC determinations of pretreatment and relapse isolates was observed in two of 48 patients who received single drug therapy (4 percent) and 0 of 45 patients who were treated with multiple drugs. In both pulmonary and nonpulmonary disease due to either species we have never observed acquired drug resistance to more than one agent or family of agents.

In summary, we find the documentation of acquired multidrug resistance in this isolate of M fortui to be suspect, the quoted incidence of susceptibility to erythromycin to be incorrect, and the case to be unlike any that we have observed. We cannot deny the possibility that drug resistance was acquired, but regret that better, more careful susceptibility data were not provided to allow us to determine this.

Richard J. Wallace, M.D., University of Texas Health Center, Tyler, Robert C. Good, Jana M. Swenson, and Vella Silcox, Centers for Disease Control, Atlanta

REFERENCES
3 Swenson JM, Silcox V, Wallace RJ Jr, Thornsberry C. Antimicrobial susceptibility of 5 subspecies of rapidly-growing mycobacteria (Abstract No. 1053). Presented at the 23rd ICAAC, Las Vegas, October 26, 1983

To the Editor:

Concerning erythromycin, correction pointed out by Wallace and colleagues is quite right. Indeed Wallace et al. showed eight of 56 (14 percent) to be susceptible rather than eight of 14. Wallace defined the standard of the 15 μg disk.

Concerning cefoxitin, Cynamon et al. reported M fortui to be susceptible to cefoxitin when the zone is 18 mm or more by disk diffusion and considered resistant when a zone of 14 mm or less was present.

Our case report demonstrated changes in susceptibility against erythromycin and cefoxitin when susceptibility testing was carried out by disk diffusion between 5/82 to 8/82. No conclusion could or would be made regarding streptomycin. It certainly would be instructive to obtain MIC data, but unfortunately, the organism is no longer available.

The conclusion that repeat susceptibility testing should be performed in patients that remain culture positive seems to be valid. What the incidence and mechanism of this resistance is will be delineated by future studies.

Lawrence Dall, M.D., Chief, Section of Infectious Diseases, University of Missouri, Kansas City

REFERENCES

Fiberoptic Bronchoscopy via Endotracheal Tube

To the Editor:

Matsushima et al in their recent article (Chest 1984; 86:184-88) demonstrated that various indices of airflow obstruction were increased when the fiberoptic bronchoscope is inserted through an endotracheal tube already in place. They, however, correctly pointed out that the advantages of airway control provided by an endotracheal tube may outweigh any drawbacks this must entail.

It should be pointed out that they made their measurements with the cuff of the tube inflated. Under normal circumstances, the cuff need not be inflated during bronchoscopy and thus alleviate any possible upper airway obstruction.

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To the Editor:

We appreciate the comments of Dr. Chung and recognize that the cuff of an endotracheal tube need not be inflated during routine bronchoscopy. We inflated the endotracheal tube cuff in our study so that the various measurements could be made. The degree of upper airway obstruction would, of course, be less without the cuff inflated.

We calculate that an 8 mm ID cuff-inflated endotracheal tube increases upper airway resistance to an 11 mm ID trachea by more than three times. The increase in resistance of an 11 mm ID trachea caused by a deflated 8 mm ID (11 mm OD) endotracheal tube would be the same as if the cuff were inflated. Of course, there would be less of an increase in Raw with a deflated endotracheal tube if the tracheal diameter were greater than 11 mm. However, the relative resistances of inflated and deflated endotracheal tubes would be almost impossible to calculate since air flowing around the outside of the tube would likely have a turbulent component and would likely follow a tortuous path.

In summary, we agree that a deflated cuff would offer less resistance to airflow and would help alleviate the possibility of barotrauma caused by a high upper airway resistance when a bronchoscope is inserted into the endotracheal tube. However, it would be difficult to calculate the magnitude of any such advantage.

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