the RV using Tc was too inaccurate to be used in individual subjects.

I suspect that Dr. Konstan's excellent correlations stem from the method used in processing the data. In our study, the RVEF was calculated from the angiograms independently and blindly from the radionuclide RVEFs. In the study by Konstan et al, this does not seem to have been the case. As anyone who has used a computer light pen or joystick to draw right ventricular regions of interest can attest, it is very easy to consciously (or subconsciously) be a little generous in one frame or a little stingy in another, especially if the operator knows what the RVEF is supposed to be from having done the first pass measurement. Unless the first pass and equilibrium RVEF measurements were done independently, one must question the validity of the reported findings. Based on our study and experience, we remain skeptical about the accuracy of Tc gated blood pool RVEF determinations.

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REFERENCES

Assessment of Airflow in Sleep Studies by Oronasal CO2 Detection

To the Editor:

Since apnea is defined by the absence of airflow, detection of airflow is an essential part of screening and all-night sleep studies. Adequate assessment of breathing during sleep studies requires the ability to detect airflow at both the mouth and nose, since many patients breathe alternately through the nose and mouth in a single night's sleep.

Nasal thermistors at the mouth and nose are commonly used to assess airflow. However, we have found it useful to use end-tidal CO2 as a measure of airflow in certain situations; eg, when calibrated end-tidal CO2 measurement is desirable, and for portable screening studies, in which we measure airflow and oxygen saturation only.

We have developed a simple, inexpensive oronasal cannula to monitor end-tidal CO2 in clinical sleep studies.

We constructed the oronasal cannula from two nasal oxygen cannulae (Hudson Company, model no 1104) by cutting two small holes with a scalpel in the back side of the first cannula, just behind the soft nasal tip. From the second cannula we cut two pieces of clear plastic tubing, each about 4 cm in length. On each of the tubes, we cut a 1.5 cm bevel on one side. We inserted the two beveled pieces through the two small holes made in the first cannula, making sure that the beveled ends were face down, and that the other end of the tubing did not block the center of the cannula (Fig 1A). We placed two small drops of cyanoacrylate glue (SuperGlue) around the two holes to hold the tubing in place. After the glue dried (10 sec), we bent the two "fangs" between thumb and finger, to make the tubing bend down past the upper lip when the prongs are inserted in the nostrils (Fig 1B). We cut the large tubing off about an inch down past the connection to the oxygen source and used a stopcock to make the connection to the CO2 analyzer.

A recording of oronasal airflow and the rib cage (RC) and abdominal (ABD) components of respiratory inductive plethysmography is shown in Figure 1C. We have found this device reliable, easy to use, and better tolerated by patients than a face mask.

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Tuberculous Bacilli and Tuberculoidosis

To the Editor:

In a recent letter, Francis and Abrahams fired yet another salvo in a long-standing semantic war of nomenclature over those unfortunate, misbegotten mycobacteria which do not belong to the species Mycobacterium tuberculosis.1 In their advocacy for a four-tiered system ("Tubercle bacilli, tuberculoid bacilli, saprophytic mycobacteria, and leprosy"), they propose the term "tuberculoidosis" for disease attributed to the "tuberculoid bacilli." While one might quarrel with their sense of verbal aesthetics in preferring these terms over "nontuberculous mycobacterial," "mycobacteria other than tuberculosis," or "atypical mycobacteria," this would likely result in the type of struggle of style that is unlikely to be resolved. Rather, we would suggest that the derivation of their terms is fundamentally unsound and would not serve to promote clarity of communication as they proposed, but would merely beget more confusion and misunderstanding.

Tubercle, the root of tuberculosis, is derived from the word used by pathologists to denote the now familiar potato-shaped ("tuber") granulomatous organization of lymphocytes and macrophages at the site of inflammation due to mycobacteria. To the extent that all of the pathogenic mycobacteria elicit similar responses, they all produce "tubercleosis." The terms "tuberculoid" and "tuberculoidosis" do not accurately portray the situation in this regard; the lesions are not tuberculoid but are, in large measure, tubercles. History and contemporary usage generally reserves the term tuberculosis for disease due to M tuberculosis (although Dorland's Medical Dictionary uses the term for "any of the infectious diseases ... caused by species of Mycobacterium ... "). To resolve this vagueness, it is incumbent upon us to develop terms for disease due to the