Table 1—Mean Results for Four CPAP Systems

<table>
<thead>
<tr>
<th>System</th>
<th>Continuous flow (mL L⁻¹)</th>
<th>Engström Erica</th>
<th>Siemens Servo 900B</th>
<th>Siemens Servo 900C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viale et al*</td>
<td>190</td>
<td>289</td>
<td>405</td>
<td>277</td>
</tr>
<tr>
<td>Katz et al†</td>
<td>33</td>
<td>36</td>
<td>33</td>
<td>37</td>
</tr>
<tr>
<td>Reduced work (mL L⁻¹)</td>
<td>0</td>
<td>0</td>
<td>235</td>
<td>68</td>
</tr>
<tr>
<td>Peak inspiratory flow (L/min⁻¹)</td>
<td>40</td>
<td>40</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>

*at 6.5 cm H₂O end expiratory pressure. †at 10 cm H₂O end expiratory pressure.

required to perform the additional work will be offset by a reduced O₂ consumption when the device performs work for the patient. At present, there are no published studies which clearly define the role of inspiratory assist in the ventilatory management of patients.

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REFERENCES

Socioeconomic Factors in Tuberculosis

To the Editor:

We read with interest the article of Davis et al1 on the causes of death in patients with active tuberculosis, since we performed a similar retrospective analysis of 1,079 patients with active tuberculosis hospitalized during the period from 1972 to 1984. In general, our findings were similar to those expressed by Davis et al.,1 except that we found a higher mortality rate (56 of 1,079 or 5.2 percent, vs 41 of 2,937 or 1.4 percent, p<0.001 by Chi-square test), a difference that can not be explained by differences in age, prevalence of drug-resistant mycobacteria, or compliance to therapy.

Of our 1,079 patients, 436 (40 percent) were young North African immigrants of fair socio-economic status who, for religious reasons, did not consume alcohol. None of them died. All 56 deaths occurred in the remaining 643 patients, who were mostly elderly or homeless people with very low socio-economic status, and of whom 486 acknowledged chronic alcohol consumption. Severe alcoholic liver disease was documented in 39 patients and was significantly more prevalent in nonsurvivors than in survivors (10 of 56 or 18 percent vs 29 of 587 or 4.9 percent, p<0.001 by Chi-square test). In our and others' view, alcoholism, the socio-economic effects related to alcoholism and in particular alcoholic liver disease seem important determinants of mortality in tuberculosis, presumably by limiting the choice and dosage of antituberculous drug therapy. Unfortunately, Davis et al give no comments on alcohol consumption in their nonsurvivors. We nevertheless presume that the high prevalence of alcohol consumption in our patients may explain our higher mortality rate.

Davis et al noted hypoalbuminemia in all their nonsurvivors1 in whom serum albumin levels had been determined. Severe hypoalbuminemia (<2.5 g/dl) was also prevalent in our nonsurvivors (24 of 56 or 43 percent), while significantly less prevalent in our survivors (41 of 1,023 or 4 percent, p<0.001 by Chi-square test). Hypoalbuminemia not related to severe alcoholic liver disease was present in only three of the 24 hypoalbuminemic nonsurvivors. Hypoalbuminemia seems a separate risk factor for mortality, presumably reflecting poor nutritional status, severity of infection and catabolic condition.

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REFERENCES

Flexible Fiberoptic Pericardioscopy

To the Editor:

We read with interest the recent article by Little et al (Chest 1985; 89:52-55). They reported their results with pericardioscopic examination as an adjunct to pericardial window in 17 patients.