able to persuade the District of Columbia government to do something similar. In the void that has existed here in 1986, a charity-operated residential facility offered a period of inpatient care, supervised taking of medication, counselling, etc., to 11 homeless TB patients on referral from one of the District hospitals or from the City Clinic. It is staffed by a group of dedicated people who work on a shoestring. At the present time, eight of the 11 patients with TB who went there have completed a period of inpatient treatment/observation and are still under some kind of medical supervision; two defaulted and one died of his disease. Some very limited public funding went into this effort, but too little. The budgets of such efforts as this facility are fragile at best. We believe full public funding should be made available for the support of the care of TB patients in facilities such as these. Perhaps it would help if the ACCP Tuberculosis Section, the American Thoracic Society, and the CDC could join together and update the old guidelines for long-term institutional care of tuberculosis patients published over a decade ago.5

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**Diagnostic Value of Nonbronchoscopic Bronchoalveolar Lavage during Mechanical Ventilation**

To the Editor:

We have read with great interest the article of Mann et al concerning nonbronchoscopic bronchoalveolar lavage (NB-BAL) using a double lumen lavage catheter for diagnosis of opportunistic infection in AIDS.

We wish to report our experience with NB-BAL performed using a 7F cuffed catheter blind-guided through the endotracheal tube via a standard ventilator adapter until distal blockage (controlled by chest x-ray examination.) If the catheter was in the proper location, the cuff was inflated and BAL performed as previously described. During the procedure, FIO2 is increased to 100 percent.

In our intensive care unit, 435 NB-BALs have been performed since 1986 to assess the causative organism of every localized or diffuse consolidation requiring mechanical ventilation.

Arterial blood gas measurements showed no significant change in PaO2 before, during, at the end of NB-BAL, and one hour following the procedure.6

NB-BAL alone provided a diagnosis in 42 percent of cases and in association with blood culture results in 19 percent. In 15 percent of the cases the consolidation was not caused by infection; in 19 percent the diagnosis was made by serology or blood culture alone. No diagnosis could be made in 11 percent of the cases. Thus, NB-BAL achieved an etiologic diagnosis in 54.8 percent of all cases.

Among the 18 immunocompromised hosts, NB-BAL achieved an etiologic diagnosis in 15 cases, six of which were Pneumocystis carinii pneumonia.

Our results are quite similar to those of Mann et al—NB-BAL is safe and effective. It appears to be a good option in the diagnosis of pneumonia requiring mechanical ventilation, even in nonimmunocompromised hosts.

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To the Editor:

We thank Dr. Piperno and colleagues for their informative commentary regarding diagnostic pulmonary lavage. We are pleased to see that their results are comparable to ours for diagnostic yield and safety. With regard to the use of double lumen lavage (DLL) for the diagnosis of infection in the nonAIDS population, our preliminary results are promising.

There is, however, a difference that may exist between the two techniques that should be pointed out. Fluid delivery and recovery with the cuffed catheter technique appears to be very similar to that of standard bronchoalveolar lavage. Fluid return in the latter technique usually ranges between 40 and 60 percent. Thus, a significant percentage of fluid remains in the lung. The authors have not given information regarding the percent return with their technique; therefore, we cannot make further comment on it. DLL return averages 102 percent. We feel that this provides a margin of safety, especially in the critically compromised host. The enhanced yield makes DLL not only useful diagnostically but also therapeutically. Unpublished data from our lab comparing weight ratios of material suctioned by DLL vs standard suctioning shows an average ratio of 3:1.

In conclusion, we think the techniques are similar for diagnostic yield but that they differ in therapeutic potential and may differ with regard to margin of safety.

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**Aspiration of an Artificial Nasopharyngeal Airway**

To the Editor:

The artificial nasopharyngeal airway is a common device used to