again (Fig 1). The "rosette"-like structure, which was pointed out by Dr. Miller, is a perivascular arrangement of tumor cells, and not a true rosette seen in carcinoid tumor.

We believe that these additional data will convince Dr. Miller of the diagnosis.

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REFERENCES

TREATING PLEURAL EFFUSION

To the Editor:

The case report on treatment of an apparently sterile pleural effusion is of more than casual interest because it recalls the widespread use of streptokinase in the therapeutic plan more than 30 years ago. Contemporary physicians and surgeons unaware of the advantages of chemical debridement are not prone to use this excellent method.

I would suggest, however, that the authors were treating two areas of loculated fluid. The fibrinous barrier between them was lysed by plasmin formed after the injection of streptokinase through the chest catheter. After breach of the fibrin partition, the upper loculation drained into the lower, and then all of the fluid came out through the intercostal tube.

Plasmin is active in a slightly alkaline range (pH 7.4 to 7.5). The slightly alkaline pH of 7.11 (erroneously reported to be acidic) should not materially affect the kinetics of this enzyme-catalyzed reaction.

The ion product of water is approximately \(1 \times 10^{-14}\) at 25°C. Because equal quantities of hydrogen and hydroxyl ions are present, pH is 7.0 (the neutral point). General usage has associated the term acidosis (as in metabolic acidosis) with a pH of approximately 7.1 which, however, is slightly alkaline. Confusion from the use of two systems of measurement may thus arise.

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References
3 Miller JM, Long PH. Surgical principles involved in the clinical use of streptokinase and streptodornase. Postgrad Med 1982; 11:188-95
4 Miller JM, Long PH. The treatment of hemotherax with particu-


PHYSICAL ACTIVITY AFTER VIRAL ILLNESS

To the Editor:

As a cardiologist interested in primary myocardial disease, I read Montague et al's "Cardiac Effects of Common Viral Illnesses" with great pleasure.

Somewhat perplexing, however, was Dr. Lerner's extraordinarily detailed accompanying editorial, in which he gives precise rules for allowing certain types and duration of physical activity (or for drinking alcohol, which stresses the myocardium).

We are, thanks to the efforts of scientists such as Drs. Montague and Lerner, beginning to appreciate the pathophysiology which may relate viral infection, repolarization abnormalities and cardiac dilation. Could it be premature, however, to give such specific rules for resumption of activity as listed in the editorial?

We do not now know enough about the natural history of viral myocardial illness to give such precise guidelines for undertaking physical activity, particularly to such a young population (mean age 26 years) as Dr. Montague stated. Giving guidelines that are that precise lends the appearance of having a more accurate knowledge of the natural history of viral illness than we now possess.

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References

WEIGHT LOSS IN SLEEP APNEA

To the Editor:

Gastric surgery is undoubtedly a mode of treatment for morbid obesity, and the recent introduction of the gastric balloon may also be another approach. Such patients often present with obstructive sleep apnea (OSA), and the treatment of their morbid obesity may be helpful in the long term. However, gastric surgery in morbid obesity has a mortality risk, particularly in the 40- to 60-year-old population of patients referred for OSA. (Mortality and morbidity risks may be lower with use of the gastric balloon, but the data are not yet available.) Also, performing gastric surgery will not lead to immediate marked weight loss, and the reduction of OSA will take months to occur. These patients may also be at even greater than usual risk in the immediate postsurgical period due to anesthesis, abdominal pain, reduction of respiratory efforts, etc. If any gastric-related treatment is considered, patients should therefore be protected prior to gastric surgery by a tracheostomy or be fitted with nasal CPAP. These two approaches will allow patients to lose weight over time without the continuous risk of nightly obstructive apneas for months to come. Powell et al have demonstrated that nasal CPAP can be used immediately postextubation in patients with narrow airways who are undergoing surgery, thereby avoiding the need for protective tracheostomy. Last but not least, it has been