Communications to the Editor

We thank Drs. Newhouse and Flaut for their interest and comments on our paper. We would offer the following comments as clarification.

The dosage of albuterol administered by MDI in our study was chosen so that we could compare our data to that of Jasper et al. These investigators had previously demonstrated that conventional dose MDI and nebulizer therapy had equal degrees of acute spirometric improvement, rates of spirometric improvement during hospitalization, and durations of hospitalization. However, both asthma and emphysema patients were included in their study. In our study of only asthmatic patients, we confirmed our findings regarding the rates of spirometric improvement and duration of hospitalization. However, we demonstrated a superior acute benefit for nebulizer therapy when compared to conventional doses (270 µg) by MDI. We believe this finding has two important consequences. First, it demonstrates the importance of having homogeneous patient populations when studying the effects of bronchodilator therapy. Secondly, it reinforces the notion that conventional (two to four) inhalations by MDI are not adequate to optimize acute bronchodilation in status asthmaticus.

As stated in our manuscript, substantial data exists to show that "conventional" doses by MDI and nebulizer therapy have equal efficacy in chronic domiciliary therapy, and in the treatment of hospitalized emphysema and mild-to-moderate asthma patients. We believe that a balanced view of our data supports a decreased use of nebulizer therapy in most hospital situations. In fact, within that last 18 months, routine nebulizer treatments have been discontinued at our institution with a substantial reduction in the cost of aerosol therapy.

Admittedly, our study was designed to compare conventional (not optimal) doses of beta-adrenergic agents. We would agree that MDI and nebulizer therapy have equal acute benefit in patients with status asthmaticus if the MDI dose is maximized. However, the dosage required to produce optimal acute bronchodilatation is variable. Also, the duration for which these optimal doses must be maintained has not been studied. Finally, studies to date have not included substantial numbers of patients with the most severe signs and symptoms (ie, CO2 retention, etc.). It is with these thoughts in mind that our present preference is to use nebulizer therapy for the early treatment of status asthmaticus, and then to switch to MDI therapy within 24 hours. However, in the final analysis it is probably the dose of beta-adrenergic agent that is delivered to the airway—rather than the delivery system—that is of greatest importance in the treatment of status asthmaticus.

Dr. Flaut's first concern was apparently that the lengths of stay of our adult patients (between 5.5 and 6.4 days) were longer than the national average for children under 15 years (3.2 days). As you are undoubtedly aware, comparing the length of stay of pediatric patients to adult patients is not valid. It has been previously documented that adult asthmatics have longer lengths of stay than asthmatic children. In fact, the national average length of stay for asthma patients increases with age. Lengths of stay increased from 4.1, 6.1, and 6.8 days for patients between 15 and 44 years, 45 to 64 years, and greater than 65 years respectively. In light of this data, the lengths of stay in our patients do not seem unreasonable.

His second concern was that use of "wheeze-free" as a criteria for discharge resulted in an inappropriate delay of discharge. The "wheeze-free" criteria was employed to provide a uniform standard for discharge for all three treatment groups. This was necessary to ensure that patients in all treatment groups had similar levels of airway obstruction at discharge. We did not state, nor did we imply, that all patients with asthma must be "wheeze-free" prior to discharge.

The question as to whether a patient should be "wheeze free" prior to discharge is an interesting one. However, this was not the question addressed in our study. Determination of the optimal criteria for hospital discharge in asthma remain to be determined. These criteria must balance the length of hospital stay against patient morbidity, mortality, and hospital readmission.

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Pott's Disease

To the Editor:

The very interesting paper on Pott's disease by Omari et al (Chest 1989; 95:145) reports new results of a classic surgical technique to approach the dorsal vertebrae transthoracically.¹

In our hospital, Pott's disease with paraplegia is frequent. In the years 1984 through 1986, we observed 230 cases of extrapulmonary tuberculosis; 16 were vertebral tuberculosis. We perform the transthoracic approach by the right side (to avoid the aorta) to treat the vertebral processes with good results.¹

Antituberculous chemotherapy with INH, rifampin and PZA daily for two months, followed by INH-PZA treatment twice a week for four months, has been successful.³

The report of Omari et al is of great interest for every thoracic surgeon that work in countries with high prevalence of tuberculosis.

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REFERENCES

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To the Editor:

I read with interest the article "Pott's disease: a resurgent challenge to the thoracic surgeon." The final paragraph, however, is misleading, implying a major role of surgical intervention in the treatment of tuberculous spondylitis. I believe the authors have failed to take account of the important work undertaken by the British Medical Research Council in a series of controlled trials of the treatment of tuberculous spondylitis.⁴ These were preceded by a report from India indicating favorable results of chemotherapy alone in the treatment of tuberculous spondylitis.⁵

Controlled trials conducted in Korea and Zimbabwe compared ambulatory treatment with bed rest,⁶ the use (or not) of plaster-of-paris jackets⁷ and surgical debridement as compared with chemotherapy alone.⁸ The studies were very carefully designed, conducted and analysed and failed to show additional benefit of modalities other than standard chemotherapy. Consequently, I believe it is misleading to suggest that "early operative intervention must be considered in patients with Pott's disease involving the thoracic spine".

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REFERENCES

5 Tuli SM, Kumar S. Early results of treatment of spine tuberculosis by triple drug therapy. Clin Orthoped 1971; 81:56-70

To the Editor:

We appreciate the letter from Drs. Cicero Sabido and Enarson indicating they too have had good results operating for tuberculosis of the dorsal spine via the transthoracic route. Though it is unclear how many of their 16 patients with vertebral tuberculosis had transthoracic surgery, he correctly points out that a right-sided approach may be used as well as a left. In approaching the inflammatory process from the left side, we have chosen to identify, mobilize and control the aorta. The right side avoids the aorta, but control would be more difficult in the event of a misadventure. Hodgson and Stock noted that, on the right side, venae cavae were difficult to identify and exposed to damage.¹ Curvature of the thoracic spine or a lesion presenting to one side may also determine the choice of right or left side.

Professor Enarson takes issue with what he feels is our implication in the final paragraph that surgery plays a major role in the treatment of tuberculous spondylitis and, particularly, with our statement that "early operative intervention must be considered in patients with Pott's disease involving the thoracic spine". He bases his objection on the early reports of the controlled trials of the British Medical Research Council (MRC) Working Party on Tuberculosis of the Spine and a previous Indian paper indicating favorable results with chemotherapy alone and failure to show additional benefit with surgical debridement.

His view of the role of surgery, however, is at variance with the more recent reports of the MRC. In their Eighth Report, published in 1982 and based on ten-year follow-up studies, they state: "When