taping the endotracheal tube at 21 cm at the teeth in women and 23 cm in men. Not mentioned in Brunel's paper (but noted in our paper) is that the lower limit of height in our patients was 168 cm in men and 158 cm in women. We have used these criteria for the past three years and have had virtually no endobronchial intubations in our 35-bed critical care center except when the height criteria were not conformed to by the respiratory therapist taping the tube. Therefore, Brunel et al's conclusion that taping the endotracheal tube at the cm markings is an unreliable method of preventing endobronchial intubation is unwarranted. As with any technique, it must be done correctly to be reliable.

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Allergies and Asthma

To the Editor:

Dr. Scheinhorn presents a convoluted argument to the conclusions of Kalliel et al for pulmonologists regarding "which asthma patients . . . merit an allergy workup?" (Chest 1989; 96:1222)

Unfortunately, Dr. Scheinhorn addresses this issue with no greater clarity than his title (Allergists non Carbonurum?). Since environmental factors frequently contribute to asthma, identification of those factors can potentially help the physician make therapeutic decisions and effectively counsel their patients. While the disease may certainly be sufficiently trivial in many patients that a comprehensive evaluation is not justified, it is a disservice to patients with asthma to suggest that those requiring polypharmacy for adequate control " . . . do not need allergy testing." I think that few would agree with Dr. Scheinhorn's judgment that the potential to simplify the medical regimen is inadequate justification for better understanding and characterization of an individual's disease.

Allergy skin testing (ie, bioassay of specific IgE) is a simple, low-tech procedure that is rapid and, when performed in rationally selected, reasonable numbers, need not be expensive. It should be less expensive than RAST, far more informative than a total IgE, and available within 15 min.

It is time to depart from doctrinaire approaches to asthma. If diagnostic procedures applicable in a physician's office provide useful information, then they should be applied eclectically regardless of whether the physician is a primary care specialist, allergist, or pulmonologist. Just as measurement of the physiologic abnormality of asthma with spirometry is no more the province of the pulmonologist than the allergist, so is an evaluation for environmental factors, including allergy skin testing, as much a responsibility of the pulmonologist caring for an asthmatic patient as it is the responsibility of the allergist to examine the pulmonary physiology.

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To the Editor:

The editorial by David J. Scheinhorn (Chest 1989; 96:1222) based on our article, "High frequency of atopic asthma in a pulmonary clinic population" (Chest 1989; 96:1336) needs clarification. In general, we agree with the factual data presented by Scheinhorn but disagree with some of his interpretation. We agree that only those allergic asthmatic patients whose symptoms are uncontrolled on routine asthma medication, and those who need maintenance oral corticosteroids therapy, should be considered for hyposensitization therapy.

We disagree with his use of the word "only" when he stated that approximately only 50 percent of adult asthmatics benefit by hyposensitization treatment. "Only" in this case refers to over 5 million asthmatics (50 percent of 250 million population in the US) and is hardly the proper word. Decreasing medications in an asthmatic patient's regimen is a worthwhile goal.

He states that routine allergy skin testing in all asthmatic patients will not help because severity of asthma (hospitalization and use of oral corticosteroids) is the same in allergic and nonallergic asthma, as quoted from our study. This equal severity was determined by history before the allergy skin test procedures were done. Therefore, these patients had not received the benefit of allergy evaluation and treatment such as determining and avoiding allergens.

He gives an additional reason for not doing allergy skin tests: patients will refuse to remove allergens such as pets anyway. The visual reinforcement of a positive skin test may help to convince them that they should remove these allergens.

We continue to believe that allergy evaluation with proper interpretation should be considered in evaluating all asthmatic patients, and we agree with Burrows et al (N Engl J Med 1989; 320:271-77) that allergies may play an important role in asthma.

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To the Editor:

Dr. Scheinhorn in his editorial, "Allergists non Carbonurum," manages to find numerous reasons to avoid the complete evaluation of the asthma patient. He does not analyse the conclusions of Kalliel et al, but states that it is only warranted to look for an etiology of a patient's asthma when the treatment program is not safe and reasonable. Reasonable apparently includes regimens consisting of up to four different inhaled medications plus oral theophylline, with safety only an issue when oral corticosteroids are utilized. We cannot imagine physicians involved in the management of any other chronic illness requiring such intensive treatment proceeding with an almost total disregard of important risk factors.

There is increasing evidence that sensitivity to environmental allergens such as dust mite, cockroach, cat dander and pollens are important risk factors for the development of acute asthma. Aggressive mite reduction measures produce clinical improvement in actively treated patients and significant reductions in nonspecific bronchial hyperreactivity. These studies demonstrate that there is a subgroup of asthmatic patients that will benefit from specific therapy, nonpharmacologic though it may be. Reasonable attempts at controlling important allergenic triggers of asthma are not only safer, but may be more cost- and time-effective than multiple medications.

Our approach to the evaluation and treatment of asthma certainly differs from the "pulmonologists' approach" advocated by Dr. Scheinhorn. Rather than a purely pharmacologic approach, we consider all important trigger factors (both allergic and non-allergic) in attempting to find the least intrusive, safest and most cost-effective management plan for our asthmatic patients.

Michael Z. Blumberg, M.D., F.C.C.P., and Jeffery L. Schul, M.D.
Sources of Endobronchial Metastases

To the Editor:

We read with interest the article of Carlin et al on "Endobronchial Metastases due to Colorectal Carcinoma." The authors state that renal and colorectal carcinomas are the most common primary tumors giving rise to endobronchial metastases, and that only 15 well-documented cases of endobronchial metastases from colorectal carcinoma had been previously reported in the literature. I would like to comment on these statements.

Though renal cell carcinoma was initially believed to be the most common endobronchial metastases, more recent reports have shown breast carcinoma to be a common source. A comprehensive review of the literature on endobronchial metastases demonstrates that renal cell and breast carcinomas are the most common primary tumors metastasizing endobronchially, while colorectal carcinomas are encountered less frequently.

The authors were able to identify only 15 cases of endobronchial metastases from colorectal carcinoma. A more thorough review of the literature reveals at least six additional well-documented cases which could add significantly to the information gathered by Carlin et al.

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REFERENCES
1 Carlin BW, Harrell JH, Olson LK, Moser KM. Endobronchial metastases due to colorectal carcinoma. Chest 1969; 96:1110-14

To the Editor:

We agree that breast carcinoma should have been included as one of the more common sources of disease metastatic to the endobronchial tree. With the increase in incidence of breast carcinoma, more instances of this type of metastatic disease may well be noted in the future. Unfortunately, the exact incidence of metastatic disease to the endobronchial tree from any source (breast, kidney, or colon) cannot be determined from information which is currently available.

The data presented in the articles by Berg et al. and Shepherd do add information to our data. The former article presents a single case of endobronchial metastatic disease, but does not provide information regarding treatment or follow-up. The latter article presents five cases with patient survival periods from seven months to ten years. Three of the five were treated with surgical resection and had the longest survival periods. In our study, each patient was deemed surgically unresectable. If the patient is a candidate for resection, then surgery should be pursued. If the patient is not a

REFERENCE
1 Marquardt DL. Immunotherapy for asthma. Pulmonary Perspectives 1989; 6:1-4