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1 Scheinhorn DJ. Allergists non carborundum. Chest 1989; 96:1292
2 Kalliel JW, Goldstein BM, Braman SS, Settipane GA. High frequency of atopic asthma in a pulmonary clinic population. Chest 1989; 96:1336-40

To the Editor:

The title translates: "Don't let the allergists run you down." It's playful, but there's nothing convoluted about it.

What's convoluted is the short-circuit reasoning that the sum of two potentials, "identification of those factors can potentially help the physician" plus "the potential to simplify the medical regimen," equals anything more than a greater potential. Until the current of outcome studies flows, the lamp of proven utility won't be lit by that potential. Until I see the light of that lamp, I won't screen for atopy with skin testing and RAST testing; I'll continue to use them in selected cases.

As far as doctrinaire approaches go, I recommend to everyone the careful and thoughtful approach to immunotherapy outlined in another recent publication of the American College of Chest Physicians.4 The author, Diana L. Marquardt, M.D., is an allergist.

Dr. Settipane and Blumberg raise questions regarding my commentary that are largely semantic; I am glad they agree with the basic facts. "Only" refers to the 50 percent chance of response to hyposensitization, not 50 percent of the number of asthmatic patients in the US. Regiments that I suggested are safe combinations of the inhaled medications mentioned, not four inhalers in a given regimen.

I think that environmental manipulations are very important; I try to effect them. I've found many patients reluctant or unable to carry them out, even when an impressive skin test or high RAST number is shown to them as evidence of need for compliance. (I work with a nurse clinical specialist who is skilled at skin testing and instructing patients in environmental modification, so my comments are not made in vacuo.)

Finally, there's the severity score. Yes, I realize the severity score is tallied before intervention based on allergy testing. That's the point. The severity score is a baseline. Before I'll be convinced that screening studies to identify the atopic subgroup are indicated, I need to be shown that the intervention changes the severity score for that subgroup.

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REFERENCE

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

Sources of Endobronchial Metastases

To the Editor:

We read with interest the article of Carlin et al on "Endobronchial Metastases due to Colorectal Carcinoma."1 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,2-4 more recent reports have shown breast carcinoma to be a common source.2-4 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.2-4

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 cases4-6 which would add significantly to the information gathered by Carlin et al.

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1 Carlin BW, Harrell JH, Olson JK, Moser KM. Endobronchial metastases due to colorectal carcinoma. Chest 1989; 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,1 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 Shepherd6 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
candidate for surgery, then a combination of Nd:YAG laser and radiation therapy can afford palliative therapy.

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REFERENCES

Advertising and Clinical Investigation

To the Editor:

The January 1990 issue of Chest presented a disturbing coincidence. A solid, four-page ad by Wallace Laboratories proclaimed—in large letters, "A Major Multicenter Study Indicates . . . etc." The therapeutic effects of Organidin were advertised and supported by a reference,1 which was at the bottom of the page. The reference read: Petty TL. The National Mucolytic Study: Results of a randomized, double-blind placebo-controlled study of iodinated glycerol in chronic obstructive bronchitis. Chest, January 1990.

There indeed, on page 75, was the article which contained some even more intriguing features. According to Dr. Petty, the steering committee for this study planned the "large multicenter, randomized, double-blind, placebo-controlled, parallel clinical trial (which) was conducted nationwide in the offices of sub-specialists (pulmonologists/allergists) to compare the efficacy and safety of iodinated glycerol vs placebo . . . ." The multicenter qualification is arresting. The physicians’ offices were the centers involved. The "approved investigators" of the "National Mucous Clearance Study" were 74 pulmonologists and one allergist, who were listed alphabetically in Appendix 1. One of the "approved investigators" did his study in a "center" located in my own city of Utica—in his office.

The most truly impressive aspect of this "nationwide study" is the barrage of presumably correct statistical analyses—but based on what kind of data or facts? The whole study rests on detailed, elegant, statistical analyses of completely subjective data. Can any valid conclusions be drawn?

A most disturbing feature of the article is what seems to be the very intimate relationship to the Wallace Laboratories of the whole study and presentation. Well before this article appeared in Chest, an advertisement for the article’s appearance on television, October 27, 1989, November 12, 1989 and December 3, 1989, was sent out. But even more disconcerting is the copy of the symposium faculty given to me by the Wallace Laboratories salesman. Included in this distinguished list is the Vice-President of Medical Affairs for Wallace Laboratories. Why?

The "hype" gets worse. We enclose a copy of the "Dear Colleague" letter from Dr. Petty on the stationery of PSL Center for Health Sciences Education, located in Denver, Colorado. At the bottom of the letterhead page is printed, "Patient Care-Teaching-Research." A telephone call to Denver informed us that, among other things, the center "did research for drug companies."

In this "Dear Colleague" letter, Dr. Petty states he "recently chaired an investigator’s meeting to review the results of perhaps one of the most ambitious clinical studies ever undertaken in the field of pulmonary medicine." What modesty! He goes on: "The findings, however, are of such import that I am compelled to submit them for peer review and subsequent publication in a leading medical journal. This, of course, precludes my disclosure of the actual data prior to publication. I can, however, share the conclusions in a more general sense."

He then presents the wonders of iodinated glycerol based on "the quality of the study design and the credentials of participating investigators."

We checked on the number of board certified pulmonologists, but instead of finding 74, we could only tabulate 53. Twenty-one were not board certified pulmonologists, although the allergist was board certified. We realize that many non-board certified pulmonologists and other specialists may be very well-qualified and capable. However, this misrepresentation—we feel—is an example of the strident, promotional, unprofessional nature of the whole presentation.

According to the undated "Dear Colleague" letter, Dr. Petty "chaired an investigator’s meeting to review the results . . . ." It seems that Dr. Petty merely reviewed an "investigation" which was organized by the Wallace Laboratories.

One wonders why a "nationwide multicenter" study was chosen. Two or three recognized "centers" could have evaluated the patients under much better and more closely controlled, reliable scrutiny. The authority of Dr. Petty and the high-sounding promotional phraseology of "nationwide" and "multicenters", will add nothing objective to the question involved, but most certainly will increase the sales of Organidin, which is produced by the Wallace Laboratories.

Dr. Petty’s study shows that iodinated glycerol seems to help patients more than the placebo. A more important observation might be—does it work any better than a saturated solution of potassium iodine? This is much cheaper, but if it disagrees with the patient then, of course, Organidin could be tried—if the patient can afford it.

The publication of this article raises a question about the peer review of Chest which, in the past, has been of high quality. Could we have a retrospective peer review, headed possibly by an astute impartial critic like Dr. Eugene D. Robin?

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To the Editor:

I am delighted to have the opportunity to respond to Drs. Ciaglia, Levy and Ryan, because it offers an opportunity to emphasize once again the care and objectivity which went into the National Mucolytic Study. It also gives me, on behalf of 75 investigators, an occasion to explain the reasons for the study.

A recent North American and European study published elsewhere (Eur Respir J 1989; 2:702-09) revealed a marked disparity in the practice patterns of European pulmonologists compared with North American pulmonologists in one area only, i.e., the very common use of mucolytic expectorants in Europe, more often than not, compared with the infrequent use of mucolytic agents for COPD by physicians in North America. Few mucolytic drugs available for prescription in this country have received any extensive clinical study. One agent, iodinated glycerol (which has been available for more than 50 years) was the subject of some preliminary and often uncontrolled evaluations. To attempt to better answer the question of the efficacy or lack of efficacy of iodinated glycerol, a steering committee comprised of an internationally-known expert in mucus formation and clearance—Dr. Adam Wanner of the