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grew Staphylococcus aureus. After frequent taps during 

6 weeks of intravenous antibiotic treatment, she showed no lasting 

response and finally consented to chest tube insertion, after which 

she had an uneventful resolution of her infection.

My assumption has been that our approach was successful because 

of aggressive use of thoracentesis. At any rate, the association of low 

pH with the need for chest tube drainage appears less certain in 

some patient populations than in others.

Finally, I would join the authors in their call for a prospective 

randomized study of conservative vs aggressive treatment of this 

process; the conservative wing of the study should include frequent 

thoracenteses when the fluid is seen to reaccumulate.

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The Mexican Asthma "Cure"

To the Editor:

I read the article by Rubin et al entitled "The Mexican Asthma Cure" (Chest 1990; 97:959-61). Dr Rubin refers to a clinic in Mexicali, Mexico, run by Drs Carrillo and Carrillo, who use "a bronchodilator medication unavailable in the United States and Canada because of the big drug companies." These medications, as Dr Rubin and his colleagues have demonstrated, contain steroids, and the patients are assured that medications which they have been 

**given** are free of side effects, and specifically that corticosteroids are not used.

I completely agree with Dr Rubin in rejecting this unethical 

practice, and by no means justify it. This is a problem that we face 

in Mexico, where the people and the doctors are afraid to use 

steroids; furthermore, the people attack the doctors who use them 

openly (and correctly) because of the risk of side effects.

However, I do not agree with Dr Rubin in calling this practice 

"the Mexican asthma cure" because it is unfair to the doctors who 

struggle to practice good medicine in Mexico.

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To the Editor:

I read with great interest the special report by Rubin et al (Chest 

1990; 197:959-61) on the "Mexican Asthma Cure." The described 

procedures for treating asthmatic patients are certainly unethical, 

and of course I agree with the conclusions of the report. Unfortunately, the report may give the erroneous impression that such 

treatment is common practice in Mexico, which is not true. No 

country is free of charlatans like the Drs Carrillo. I think that the 

report might have been more accurately titled "The Carrillo Asthma 

Cure."

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To the Editor:

The report by Rubin and his co-workers' on the treatments 

containing steroids offered to asthmatic patients by a Mexicali clinic 

uses in the title the term "the Mexican asthma cure." I consider 

this title misleading and derogatory to our country and to the 

physicians in Mexico because it generalizes about a practice followed 

by very few and endorsed by no medical association or university 

in Mexico. I think that this type of expression should not be allowed 

in scientific journals. Unfortunately, the cited article is not the only 

example of the subject of my protest.**

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To the Editor:

The title of my article, "The Mexican Asthma Cure," was taken directly from my index patient, who used these words to describe the medications that she was taking. It is unfortunate that this title could be seen as insulting to the many fine and ethical medical practitioners in Mexico, and for this I apologize. This type of quackery is no more representative of the usual practice of medicine in Mexico than chelation therapy for arteriosclerosis is representative of accepted practice in Canada or the United States.

Honest physicians in any country who give quality medical care to their patients don't have magical "cures" to advertise. The disreputable few who choose to sell false hopes to desperate patients become the unwanted representatives of foreign practice when they market to wealthy clients abroad. This is what happened in Mexico with laetrile ("vitamin B-17"), and is happening again with the marketing of oral corticosteroids as a cure for asthma. I was very pleased when Dr Soffer agreed to name the physicians in Mexicali responsible for this hoax so that their colleagues in the same city would not have their reputations tarnished by the practice of the Drs Carrillo.

If not for the help of honest medical colleagues in Mexico City and Mexicali I would not have been able to collect and verify the information used in preparing my article. I hope that my colleagues in Mexico accept my sincere apologies for any suggestion that this "cure" in any way represents acceptable medical practice in Mexico. With the help of honest physicians like Drs Chavage, Cicero, and Perez-Padilla and medical journals like Chest, with their willingness to expose medical quackery, we may be able to put these charlatans out of business. That will be the finest service that we can do for the reputation of physicians, both in Mexico and in Canada.


Caffeine, Prostacyclin, and Exercise-Induced Bronchoconstriction

To the Editor:

Kivity et al (Chest 1990; 97:1038-85) documented a beneficial effect of caffeine, a methylxanthine, in the prevention of exercise-induced bronchoconstriction (EIB) in ten young asthmatic patients. It has been suggested that EIB in fact represents a vascular phenomenon occurring secondary to thermal gradients that result after exercise or hyperventilation.1

Caffeine administration has been shown to stimulate the production of prostacyclin in vitro.2 The effect of prostacyclin as an inhibitor of platelet aggregation and as a vasodilator has been well documented. This vasodilatory effect of caffeine-induced prostacyclin production could conceivably account for the observed salutary effect of caffeine on EIB. It is plausible that caffeine diminishes EIB via prostacyclin-mediated bronchovascular vasodilatation with a consequent reduction in the end-hyperventilatory thermal gradient believed to be necessary for airway obstruction to occur.

Interestingly, ascorbic acid, which like caffeine has been demonstrated to attenuate EIB, has also been found to stimulate prostacyclin production.3 It again seems conceivable that this particular effect of ascorbic acid could occur through a prostacyclin-mediated vasodilatory action affecting intrabronchial thermal gradients, similar to that observed with caffeine. Such a prostacyclin-mediated effect could help explain the findings of Kivity et al regarding prevention of EIB by caffeine, as well as the earlier reported findings relating pretreatment with ascorbic acid to diminished EIB.

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Accidental Methacholine Bronchoprovocation in a Laboratory Worker

To the Editor:

We have recently encountered episodic bronchospasms in a pulmonary function technician. The patient is a 26-year-old woman with a 6-year history of chronic stable asthma, with no hospitalizations, emergency room visits, or work absence during the past year. Her treatment included theophylline (1,200 mg in divided doses), albuterol and ipratropium (three puffs four times daily), cromolyn sodium (two puffs four times daily), and triamcinolone aerosol (three puffs four times daily). We observed two episodes of symptomatic asthma immediately following passive inhalation of methacholine during her performance of bronchoprovocation testing on two clinic patients. Seated approximately 3 ft from patients who received a single breath of a 5 mg/ml concentration of methacholine, she experienced greater than 20 percent reduction in FEV1. On both occasions she responded quickly to treatment with nebulized albuterol. To determine her nonspecific bronchial hyperreactivity, we performed methacholine challenge using the tidal breathing method of Juniper et al.1 To simulate clinical testing, she had received asthma therapy approximately two hours prior to testing. We found a 41 percent reduction in FEV1, in response to a methacholine concentration of 0.04 mg/ml. Subsequently, we have attempted to restrict her performance of bronchoprovocation or have pretreated her with albuterol immediately prior to testing, with no further problems.

Little information exists concerning occupational hazards associated with respiratory therapy, although pentamidine aerosol-associated tuberculosis has been reported in respiratory technicians.2 Methacholine is generally not considered an occupational hazard,

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