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Agranulocytosis associated with "Mexican aspirin" (dipirona):
evidence for an autoimmune mechanism affecting multipotential

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 representa-
tive 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 Chavaje, 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.

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Caffeine, Prostacyclin, and Exercise-
Induced Bronchoconstriction

To the Editor:

Kivity et al (Chest 1990; 97:1083-85) 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.

Caffeine administration has been shown to stimulate the produc-
tion of prostacyclin in vitro. The effect of prostacyclin as an
inhibitor of platelet aggregation and as a vasodilator has been well
documented. This vasodilatory effect of caffeine-induced prostac-
cylin production could conceivably account for the observed
salutary effect of caffeine on EIB. It is plausible that caffeine
diminishes EIB via prostacyclin-mediated bronchovascular vasodi-
atation 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 dem-
onstrated to attenuate EIB, has also been found to stimulate
prostacyclin production. It again seems conceivable that this
particular effect of ascorbic acid could occur through a prostacyclin-
mediated vasodilatory action affecting intrabronchial thermal gra-
dients, 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 bronchospasm in a
pulmonary function technician. The patient is a 26-year-old woman
with a 6-year history of chronic stable asthma, with no hospitaliza-
tions, 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 tiamcinolone 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. To simulate clinic 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 associ-
ated with respiratory therapy, although pentamidine aerosol–asso-
ciated tuberculosis has been reported in respiratory technicians.
Methacholine is generally not considered an occupational hazard,