"Life satisfaction," which Shepherd et al also measured, is only a general measure of psychological distress. When psychological distress was investigated in a much larger sample (n = 176), less favorable results were found. This may justify investigating the psychological difficulties of adult CF sufferers in more detail.

Adult CF patients do not, except rarely, suffer from mental illness. They may experience neurotic symptoms, such as anxiety, low mood, or stress. All people experience these to some extent, so the choice of where to draw a line in psychiatric investigations to define some symptoms as abnormal is critical. The questionnaires that Shepherd et al developed for their study do appear to genuinely inquire about those areas of life and social satisfaction that the authors intended to investigate. Since these questionnaires are not supported by reliability or validity data, there must remain some doubt that the authors drew their lines in acceptable positions.

The authors failed to interview a third of the patients, and this may introduce bias.

The adult CF population is expanding. Shepherd et al have increased our knowledge of how they fare. Perhaps future studies should use interviews as a more reliable way of producing psychological data and should use recognized rating scales of known reliability and validity to address in more detail the occurrence of psychological symptoms.

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To the Editor:

Dr Aspin correctly notes that only 67 percent of the eligible subjects participated in our study on the psychosocial functioning of adults with cystic fibrosis. Yet a 100 percent participation rate is virtually never possible, and the participation rate in our study falls midway between the 59 percent and 85 percent achieved in the two studies cited by Dr Aspin. Possible bias from the failure to include nonrespondents is always a concern. However, it is useful to consider what forms such bias might take. The reason for studying the psychosocial health of physically ill persons in the first place is the assumption that physical health can affect psychosocial health. On all the physical health variables available for comparison, however, we found no significant differences between the CF participants and nonparticipants in our study. Thus, to the extent that physical health does affect psychosocial health, it seems reasonable to assume that psychosocially the CF nonparticipants would resemble the CF participants. If the CF participants and nonparticipants did differ psychosocially, it would be for reasons other than their having CF.

Dr Aspin also suggests that the findings of Cowen et al are at odds with our own. These investigators, however, never studied "psychological distress" (nor did they study 176 adults; when limited to patients aged 20 years or older, n = 105). The specific results of Cowen et al on which Dr Aspin bases his statement are in turn based on a nearly 40-year-old measurement tool of debatable validity, and the overall conclusions of Cowen et al are that older patients with CF possess "a generally normal self-concept" and "cope with their intellectual, developmental, and socioeconomic tasks commensurate with normal age expectations."

As to the validity and reliability of our measures, the questions pertaining to social network density are closely adapted from those used in the RAND Health Insurance Study, and their validity and reliability have been thoroughly analyzed. Other measurement tools that we used have been less well characterized, and it would indeed be useful to know the psychometric properties of these instruments. However, we believe that the questions we used have high face validity. Moreover, the use of a controlled design reduces the possibility that measurement error is responsible for our results. If the measures do have psychometric weaknesses, the responses of subjects with and without CF should be equally affected.

The importance of using a controlled design is related to a more substantive question raised by Dr Aspin: where to draw the line between normal and abnormal. Such an endeavor raises a host of questions (many common traits and behaviors in our society should rightly be considered "abnormal".), and we make no claims as to where such a line of demarcation should fall. Our results do suggest, however, that wherever one chooses to draw such a line, the percentage of subjects who fall on either side of it will be similar both for adults with CF and for their healthy peers. Dr Aspin suggests that future studies may benefit from the use of psychological interviews rather than questionnaires. This is a matter of methodologic preference, but it should be kept in mind that no matter how well-conducted, valid, or reliable such interviews may be, in the absence of similarly obtained data from a control group, it is impossible to make valid conclusions about how normal or abnormal, healthy or unhealthy, one group may be relative to another.

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Mediastinal Pseudocyst Associated with Chronic Pleural Effusions

To the Editor:

We read with great interest the article by Zeitlender et al (Chest 1990; 97:1014-16) on mediastinal extension of a pancreatic pseudocyst presenting as a chronic pleural effusion. We recently were faced with a similar case and had the same concern about how to proceed in treating the cyst in a patient who was not a surgical candidate.

A 55-year-old black man was admitted to District of Columbia...
General Hospital with a 2-week history of dyspnea, nonproductive cough, and weight loss. Despite a strong history of ethanol abuse, he denied any prior history or symptoms of pancreatitis. The initial chest x-ray film demonstrated a large left pleural effusion and a small right pleural effusion. The left effusion was hemorrhagic with an elevated amylase concentration of 3,230 Somogyi units. The serum amylase concentration was 66 Somogyi units. Pleural biopsy was negative for acid-fast bacilli and malignancy. The right pleural effusion was transudative with an amylase concentration of 46 Somogyi units. The patient underwent tube thoracostomy and drainage of the left pleural effusion. A subsequent computed tomographic (CT) scan of the chest and abdomen showed a posterior mediastinal cystic mass with extension into the abdominal cavity, suggesting the diagnosis of a mediastinal pseudocyst. Conservative management with hyperalimentation was attempted; however, 5 weeks later the patient developed Staphylococcus aureus bacteremia and hemodynamic instability necessitating the administration of vasopressors. We proceeded with CT-guided percutaneous catheter drainage of the intra-abdominal cyst, which resulted in concurrent drainage of the thoracic cyst. After initial improvement, the patient's condition deteriorated over the ensuing 4 weeks. Candidemia developed, and the patient eventually died.

This case demonstrates an alternative approach to that of Zeilender et al to a patient who is not a surgical candidate if conservative therapy and hyperalimentation are not effective. Often, CT-guided drainage of the abdominal cyst will also result in drainage of the thoracic component and clinical improvement. There have been two previous reports documenting this technique in the management of complications arising from a mediastinal pancreatic pseudocyst.\textsuperscript{1,2} Our case underscores several points in the approach to these patients. First, although a history of pancreatitis or abdominal trauma can be elicited in most cases, symptoms relating to the pleural effusion may be the sole manifestation of pancreatitis. Second, the elevated fluid amylase concentration was the first clue to the diagnosis; therefore, the amylase level should be determined routinely in evaluation of chronic effusions. Some reports suggest that a pleural fluid amylase value significantly higher than the simultaneous serum value is pathognomonic for a pancreaticogenic effusion.\textsuperscript{3,4} To a lesser degree, this can also be seen in some malignant effusions. Third, we concur that CT is a sensitive tool in confirming the diagnosis.

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5 Dewan NA, Kinney WW, O'Donohue WJ. Chronic massive pancreatic pleural effusion. Chest 1984; 85:497-501

To the Editor:

We thank Drs Read and Richardson for their comments. We agree that CT-guided drainage of the abdominal cyst will often result in drainage of the thoracic component and is a therapeutic alternative in the patient who is not a surgical candidate.

Our patient eventually underwent endoscopic retrograde cholangiopancreatography (ERCP), which demonstrated the fistulous tract between the pancreatic duct and the mediastinal pseudocyst (Fig 1). Thus, ERCP may be an alternative or complementary modality for diagnosis of pancreatic pseudocyst formation.

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Self-extubation

To the Editor:

We read with interest the article by Coppolo and May\textsuperscript{1} regarding self-extubation. We would like to share a similar prospective study with a smaller number of patients done at our institution over a 7-month period from February 1989 to September 1990.\textsuperscript{2}

We compared the effects of sedation and restraints on patients who extubated themselves while on a ventilator. An average of 16 patients per day were followed up over a 7-month period. The

\textsuperscript{1} Coppolo ME, May LK. Self-extubation in the intensive care unit. A retrospective study. Chest 1991; 100:1319-1322

\textsuperscript{2} O'Donohue WW, Kinney WW, O'Donohue WJ. Chronic massive pancreatic pleural effusion. Chest 1984; 85:497-501