with observation. An operation should have been performed only when and if the patient became symptomatic.

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REFERENCES

Acute Asthma
Utility of Admission Chest Radiography

To the Editor:

I read with great interest the article by White et al,1 which appeared in the July 1991 issue of Chest. The authors raised several important points concerning the utility of chest radiographs in adults admitted for exacerbations of bronchial asthma. I feel, however, that several aspects of their study must be addressed.

First of all, the study is relatively small (n = 58) and uncontrolled, and involves patients from only one institution over an extremely short period, which I feel brings into question whether their findings can be generalized to the population at large. The emergency room at Columbia-Presbyterian Medical Center serves a largely poor inner-city population, who often lack adequate primary health care and thus might be reasonably expected to present with more severe disease. In addition, this study included only patients who failed to respond to 12 h of bronchodilator therapy, and thus probably omitted many patients who would have been admitted to other hospitals, especially those in the community setting. In light of these factors, I feel that there exists a question of whether the authors’ conclusions concerning the utility of chest radiographs, and their findings of a high percentage of abnormal radiographs in adults admitted for bronchial asthma, can be uniformly applied to all adults admitted for acute asthma.

I do believe that the authors have raised some interesting questions concerning previously held beliefs about the role of the chest radiograph in the initial admission workup of the adult asthmatic patient; however, a larger, controlled study is probably required in order to define the exact role of the chest radiograph in these patients.

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Harlem Hospital Center,
New York

REFERENCES
1 White CS, Cole RF, Lubetsky HW, Austin JHM. Acute asthma: admission chest radiography in hospitalized adult patients. Chest 1991; 100:14-6

To the Editor:

After review of the letter from Dr Gettler, my coauthors and I find ourselves in agreement with most of his statements. However, we feel obliged to mention that we addressed many of the same points in discussing the high rate of radiographic abnormalities in the study. Our study population, while not large, appears to be of sufficient size for the data to support our conclusions.

The inner-city location of this study is particularly relevant in view of the increasing number of patients who use the emergency room as their primary source of health care. It is uncertain whether our conclusions can be applied to patients with refractory asthma who are admitted to community hospitals, and no prospective studies have been performed in this setting. We hope that our findings will encourage such a study.

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Diagnostic Imaging Department,
University of Maryland Medical Center,
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Chronic Mountain Sickness

To the Editor:

I read with interest the case report by Klepper et al,1 which appeared in the September 1991 issue of Chest. I have some questions regarding that case of chronic mountain sickness. Why did the patient require tracheostomy? What was the long-term follow-up with oxygen therapy or with moving to sea level? I note that the PaCO2 fell from 66 mm Hg to 60 mm Hg over one week. Was this the onset of a clinical response to a low-altitude environment?

In a similar case, which I reported in Chest in 1984,2 respiratory acidosis resolved over two months with oxygen therapy at altitude and then relocation to sea level. Polycythemia improved without phlebotomy over six months. Clinical improvement at sea level is usual in chronic mountain sickness and is one feature that establishes the diagnosis.

Christian Gronbeck III, M.D.,
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REFERENCES
2 Gronbeck C III. Chronic mountain sickness at an elevation of 2,000 meters. Chest 1984; 85:577-78

To the Editor:

We appreciate the comments by Dr Gronbeck regarding our report. The patient had a tracheostomy because there was the concern that part of the sleep-related respiratory difficulties might have been due to obstructive sleep apnea (the initial sleep study had shown some episodes of obstructive apnea, although this was not the major finding). As we reported, the follow-up sleep study revealed minimal improvement after the tracheostomy. In retrospect, it appears that this procedure may not have been necessary until after other management options had been considered.

Unfortunately, the patient returned to Mexico and is lost to follow-up. We also believe that the decrease in PaCO2 that occurred during the hospitalization reflects a favorable response to our low-altitude environment in Houston. We agree that a long-term favorable response to a low-altitude setting would have been further supporting evidence in this case.

William L. Eschenbacher, M.D.,
Pulmonary Section,
Baylor College of Medicine,
Houston

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