Bronchoscopy, but 1 year later the patient coughed it up.

Depending on the composition of the aspirated FB and its location, an FB may remain in situ without causing symptoms. Attempting to remove a suspected FB is appropriate, however, observation may be reasonable, because of the rare occurrences of spontaneous expectoration.

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REFERENCES
1 Jackson C, Jackson CL. Diseases of the air and food passages of foreign body origin. Philadelphia: WB Saunders Co, 1936

A Historical Footnote to Respiratory Therapy

To the Editor:

The thoughtful editorial on ventilatory weaning by Brandstetter and Tamarin, which appeared in the June 1992 issue of Chest, is unlikely to change current usage. The term "weaning" is much older than the 20 years they suggest—30 years at least—and very probably much older even than that. Another point, the oxygen T piece also is much older than is currently believed in the United States, dating not from 1970, but at least from 1961. As Dalton et al. point out, the T-piece principle was first described by Dr. Philip Ayre (1902-1979), who told me that he thought of the idea following rupture of a child's lungs in the days before reducing valves were fitted to gas cylinders. The original device is now exhibited in the Department of Anaesthesia, Newcastle General Hospital, England, where he worked. As I recently discovered, the T-piece principle was used for oxygen therapy with continuous positive airway pressure in 1950, and a modification of the original, rather crude diagram appeared in 1952. The oxygen T piece is sometimes called "the cigar" here because of the mist (smoke) that appears from its end when it is linked to a nebulizer.

Finally, it is reassuring to note that our colleagues in the United States have at last accepted the overriding importance of muscle fatigue in failure to wean (er, liberate) the patient from mechanical ventilation, a problem many of us in Europe have recognized for over 30 years—perhaps even 40 years, since the poliomyelitis epidemic of 1952. Of course, this letter won't change historical perceptions either.

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REFERENCES
1 Brandstetter RD, Tamarin F. Weaning is demeaning: it's time for liberation [editorial]. Chest 1992; 101:1498
2 Gilston A. The management of respiratory distress after cardiothoracic surgery. Thorax 1962; 17:139-45
4 Gilston A. A tracheotomy T-piece. Lancet 1960; 1:1326

Activation of Bone Marrow Eosinophils in Asthma

To the Editor:

Eosinophils are thought to be important inflammatory cells in asthma, especially late-phase asthmatic reaction. Most eosinophils in asthma are activated in the airway. Regarding the genesis of tissue eosinophil accumulation, it is generally accepted that the recruitment of eosinophils is caused or modulated by chemotactic factors and cytokines, which are released from mast cells, TH2-type cells, and other inflammatory cells. Eosinophils can then be activated, and their survival can be prolonged by interleukin-5 and granulocyte/macrophage colony-stimulating factor in the tissue. There are few reports of activation of bone marrow eosinophils.

In order to investigate the activation of marrow eosinophils, we performed an immunohistochemical study of the bone marrow obtained from a patient who died of a severe asthmatic attack. We used an eosinophil granule monoclonal antibody (EG2) as a marker of activated secreting eosinophils. We found that a large number of immature eosinophils, which had a large nucleus with a large amount of cytoplasm and were proeosinophils, were stained by EG2 antibody (Fig 1). In contrast, in control bone marrow obtained from an autopsy case of apoplecty without asthma, only a few eosinophils...