We are not aware of any validated set of “several questions on respiratory symptoms” showing high specificity. If several questions on symptoms are going to be used to identify asthma, then the sensitivity and specificity of these combinations must be validated. Such a combination will probably increase the sensitivity at the expense of lower specificity. This will cause an underestimation of the relationship between asthma and the determinants of the risk.

We believe that descriptive epidemiologic studies, or prevalence studies, of asthma have limited scientific interest. Forthcoming studies must be developed toward an analytic design, i.e., they must allow us to calculate the risk of developing asthma in relation to certain factors. This is the reason for preferring diagnostic measures with high specificity.

Our review discussed studies of asthma in adults. In studies of children, where the incidence and prevalence are much higher, high sensitivity is more important for obtaining high positive predictive value, and specificity is somewhat less crucial.

Another challenge in this research field must be to develop methods permitting us to study the incidence of asthma. Incidence is a much better measure if we want to estimate the risk of developing asthma in relation to certain factors. Thus, in forthcoming studies, we shall try to develop methods to study the incidence of asthma. Such methods are not well established, and we know little about their sensitivity and specificity.

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Long-Term Oxygen Therapy
Is It Necessary to Increase the Nocturnal Flow by 1 Liter?

To the Editor:

The American Thoracic Society suggests that in long-term oxygen therapy (LTOT), the nocturnal oxygen flow should be increased in 1 L/min above the daytime administered rate. Our aim was to evaluate the need for such an increase in all COPD patients receiving LTOT.

We studied 34 patients (FEV1 = 0.78 ± 0.26 L) who qualified for LTOT. In addition to measuring blood gas values (ABL-3 Radiometer, Copenhagen) while breathing room air, oxyhemoglobin saturation (SaO2) was registered (Oxipulse Radiometer, Copenhagen), with hyperoxia at the prescribed flow, both with the patient awake and at rest for 2 h, and throughout the night. The data were analyzed with the Student’s t test for paired and unpaired series.

In the first stage of our study, we observed that 29 of the patients, in spite of not receiving an increase in oxygen flow, the time they spent with SaO2 between 90 and 80 percent was only 19.7 ± 0.4 min and at no point had a percentage of SaO2 lower than 80 percent. In this group of patients, there was no difference between mean SaO2 while awake (94.0 ± 1.6%) and while asleep (93.1 ± 1.4%). The remaining five patients spent 151.1 ± 95.7 min with SaO2 between 90 and 80 percent, and 25.3 ± 22.1 min with SaO2 between 80 and 70 percent. In this group of patients, nighttime SaO2 (84.2 ± 2.8%) was lower (p<0.01) than daytime SaO2 (92.9 ± 1.7%). In addition, there were significant differences between the two groups of patients in mean SaO2 both in the night (p<0.001) and in the day (p<0.001).

In the following stage of the study, the five-patient group received an increase of only 0.5 L/min in nocturnal oxygen flow, which was also maintained throughout the day, and their new SaO2 was at no point lower than 90 percent. The mean SaO2 of these patients in the night increased to 91.8 ± 1.5%, which was not significantly different from their new daytime value of 93.8 ± 1.9%. The previous differences in SaO2 between the two groups similarly disappeared.

When we searched for clinical or functional differences between both groups, we observed no differences in FEV1 and FVC, course of their illness, degree of dyspnea, h/d of LTOT, and time since LTOT prescription. Differences were found with the patients awake while breathing room air in PaO2 (53.2 ± 6 mm Hg and 46.1 ± 55.4 mm Hg) (p<0.05), PaCO2 (46.8 ± 6.7 mm Hg and 55.6 ± 10.3 mm Hg) (p<0.05), and SaO2 (87.5 ± 3.9% and 81.0 ± 5.3%) (p<0.01).

Given the lack of data available in the literature and the fact that none of our patients, including the most hypoxic, required a 1-L nocturnal increase in O2 flow, we suggest that a revision of the recommendation of the American Thoracic Society may be suitable.

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Lipoid Pneumonia Due to Intranasal Application of Petroleum Jelly
An Old Problem Revisited

To the Editor:

Brown and colleagues recently reported a case of lipid pneumonia caused by intranasal application of petroleum jelly and stated that they were not aware of any previous reports of such occurrence. This brought back memories of a patient I had treated in 1975 and reported about in the Annals of Internal Medicine.

My patient, a 75-year-old man, had a thoracotomy for a suspected lung carcinoma and the surgeon resected an "oily