the only required diagnostic criteria, would give a better picture of current man to woman representation of this disease.

Reich and Johnson then present their argument that the bronchiectasis seen in most women with MAC disease is a causative factor rather than a consequence of the disease. Unquestionably, there are some women (and men) with lingular and middle lobe syndromes unrelated to MAC disease. The studies by Hartman et al1 and Swensen et al (Chest 1994; 105:49-52), which prompted our initial editorial, clearly pointed out the significance of coexisting nodular disease as a major radiographic marker for identifying the patients with bronchiectasis who had MAC disease. More than 50% of patients with bronchiectasis did not have nodular disease and had negative mycobacterial cultures. They presumably have another disease. There are also unquestionably some patients, especially those with prior treated mycobacterial infections, eg, Mycobacterium tuberculosis, or cystic fibrosis, in which the MAC follows in the wake of already established bronchiectatic areas of the lung. In patients with coexistent nodular disease and no other recognized disease producing bronchiectasis, however, we believe the absence of long-term serial radiographic and clinical studies leaves the door open to the possibility that the bronchiectasis is a consequence rather than a cause of many of the patients with both diseases. A recently submitted abstract by Kuz and colleagues7 looked at serial computed tomography of pulmonary infections caused by MAC in patients without predisposing conditions. They noted that clusters of small peripheral nodules, with normal bronchi, was the initial radiographic abnormality, which progressed to bronchial thickening of the associated bronchi, and ultimately to cystic bronchiectasis. The latter change was seen a mean of 11.3 years after the onset of symptoms. This study suggests that bronchiectasis is a part of the disease process of MAC, at least in some patients. Again, more detailed studies of patients who present with lingular and middle lobe syndromes with assessment for associated nodular disease, careful evaluation for mycobacterial infection, and serial follow-up are needed to resolve satisfactorily this question of the relationship of bronchiectasis (cause or consequence) to MAC.

The final theory presented by Reich and Johnson is that of voluntary cough suppression as a cause of the middle lobe-lingular bronchiectasis and subsequent associated MAC disease. In our opinion, voluntary cough suppression is not sufficiently well described, or accepted as a definable entity, to attribute any pulmonary disease to this phenomenon.3,4 We would accept this as one of a number of potential possibilities to explain the bronchiectasis and MAC disease occurring in women. Genetic and age related immunologic factors, unknown environmental risks, etc, should also be considered as potential factors that may be responsible for the disease. Additional clinical, pathologic, and epidemiologic studies of this “silent” epidemic are needed to turn theories into fact. Women with disease, it is your turn to stand up and be counted, and counted correctly.

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Producing Red Herrings

To the Editor:

Jackson et al1 in the June issue of Chest confused Murphy's Law ("What can go wrong, will go wrong." ) with Sutton's Law ("Go where the money is." ) in their article "Left Upper Lobe Mass and Diffuse Reticular-Nodular Infiltrate."

As I grew up in Brooklyn, New York in the 1940s and 1950s, the bank robbing exploits of Willie "the actor" Sutton were as memorable as his remarks soon after capture. When asked why he always robbed banks, he replied, "That's where the money is."

As a medical student in the early 1960s at SUNY Downstate Medical Center, I was privileged to work at the Cardiology Service of the legendary professor of medicine and former chairman of the department, William Dock, who first applied that aphorism ("That’s where the money is." ) to the practice of clinical medicine. He admonished students to use the single test most likely to bear fruit before undertaking a series of studies that do little more than produce red herrings.2

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REFERENCES


Hospital-Acquired Morbidity and Circadian Rhythms in Patients in the ICU

To the Editor:

A recent article by Meyer and colleagues1 published in Chest have shown effects of adverse environmental factors in the ICU. We not only concur with their findings in the Journal but also we would like to emphasize that this is a significant factor in hospital-acquired morbidity (HAM) and remains unappreciated by the profession. We similarly reported ICU psychoses, especially common in postoperative elderly patients, have direct relevance to acute disturbance of circadian rhythms.2,4 Adverse environmental factors in the ICU should be part of ICU committee agenda and should reflect the level of quality of care and standards. Unfortunately, most ICU committees suffer from Lister-Koch syndrome, and even discussion of adverse environmental factors are considered "flaky." Drs. Lister and Koch were giants of Victorian science and their discoveries led to decreases in mortality due to infectious diseases. Prevention of nosocomial infections in the ICU is important, minute attention to aseptic techniques is well admired, but researching and studying other causes of morbidity in the ICU should not be ignored. It is high