concrete evidence is forthcoming one should adhere to the first principle of clinical medicine, “First do no harm.”

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REFERENCES

Isoniazid Safety

To the Editor:

I read with interest the recent report examining the underutilization of isoniazid preventive therapy among elderly patients (CHEST 1995; 108:706-11), and I commend the authors for their comprehensive examination of both utilization and completion rates. As clearly highlighted by the accompanying editorial comment (CHEST 1995; 108:596-98), physicians who either misunderstood or do not accept the current tuberculosis prevention recommendations1 are directly responsible for this unfortunate situation.

Many critical elements of the results are summarized in Tables 1 and 2 of the article (CHEST 1995; 108:706-11); however, I believe the authors have erred both in the construction of the tables and in the text describing their content. The tables stratify persons into those with a liver function test (LFT) result two times the upper limit of normal or greater and those with an LFT three times the upper limit of normal or greater. However, what the data seem to actually show is stratification according to an LFT between two and three times normal vs an LFT three times normal. This is further confused in the text where it is stated that among persons who discontinued therapy, “...8 had a maximum twofold rise in liver function values.” Since Table 1 (CHEST 1995; 108:706-11) seems to show that there were eight patients who discontinued an LFT between two and three times normal, are we to assume that each had an LFT that was exactly twice normal? On the same page, the authors state, “In persons with LFT results three times normal or greater, a significantly higher percentage did not continue therapy (14.5%) compared with those who completed therapy (3.3%).” Similar comparisons are made for black patients and white patients. The data in Table 1 (CHEST 1995; 108:706-11) show that among 32 persons with an LFT three times normal or greater, 24 (75%, not 14.5%) did not continue therapy and 8 (25%, not 3.3%) completed therapy. Likewise, the comparisons for black patients and white patients do not agree with the data in Table 1 (CHEST 1995; 108:706-11).

The encouraging finding of this study is that among 412 elderly patients taking isoniazid for tuberculosis prevention, there were no cases of drug induced hepatitis and only 17 patients with an LFT three times normal or greater. This may help to persuade physicians that isoniazid can be safely used by persons of any age as long as appropriate follow-up is provided to the patient.

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To the Editor:

I think Dr. Beller’s remarks are appropriate and deserve a response. I admit that the tables are a bit confusing. We tried to divide the patients with abnormal liver function test (LFT) results into two groups: group A (LFT two times normal or greater but less than three times normal), and group B (LFT three times normal or greater). Hence, the statement should have been “8 had LFT elevation of less than three times normal.”

In the racial comparison in Table 1, we took the percentage of the total who stopped therapy (166 rather than 32 who had LFT three times normal or greater). I am sorry if some readers found this confusing. Throughout the statistical analysis, we took the percentage of the total of those who completed therapy and those who did not. This kept the analysis simple and consistent. Regardless of the method, the final conclusion remains unchanged: isoniazid preventive therapy is generally safe and underutilized.

I agree with Dr. Beller’s final statement that we should emphasize that “isoniazid can be safely used by persons of any age as long as appropriate follow-up is provided to the patient.”

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Relationship Between the 6-Min Walk Test and Maximal Oxygen Consumption

To the Editor:

The article by Cahalin et al (CHEST 1995; 108:452-59) showed that the relatively simple 6-min walk test (6′WT) can predict maximal oxygen consumption (V̇O₂max) obtained from cycle ergometry in lung transplant candidates. Although I agree with the authors that a reasonable correlation existed, there are some things which I, and I am sure that others, would have liked to see in the article.

It is stated that supplemental O₂ was used during the 6′WT, but it appeared that cycle ergometry studies were done while the candidates were breathing room air. Arterial blood gases were obtained at rest and at maximal cycle exercise and my estimations of the calculated O₂ saturations were 93% at rest for both groups A and B, while during exercise the saturations fell to 88% in group A and to 87% in group B. It would be interesting to know what the saturations were at the end of the 6′WT while supplemental O₂ was used. If desaturation during the 6′WT was prevented by the supplemental O₂, then the derived prediction equation to obtain V̇O₂ max from the 6′WT would be invalid.

Also, the statement that encouragement to go further during the