thymectomy. We described an alternative approach, which we have found to be safe and to be able to accomplish a complete thymectomy. Dr. Yellin raised several points in his letter. First, we regard the superior cosmetic results from the video-assisted thoracoscopic surgery (VATS) approach as a bonus, but the real advantage we have found is that by minimizing chest-wall trauma, patients are more willing to accept early surgical treatment. Second, selective one-lung ventilation is standard for VATS, and we have not found intubation with a double-lumen tube to be more “complex” or indeed associated with more complications compared with a single-lumen tube. Third, myasthenic patients with thymomas present a technical challenge with VATS, but we have found our described technique to be applicable to thymoma up to 4 cm. However, we believe that this approach should only be performed by those with considerable experience in VATS.

We are cautious in advocating video-assisted thoracoscopic thymectomy for general use as our experience is still limited and our data preliminary. Nonetheless, we are encouraged by our early results. We believe that minimizing chest-wall trauma is particularly important to the functional recovery of myasthenic patients following thymectomy. More work is needed to better define the role of VATS in thymic surgery. We would like to conclude with a quotation from Roger Bacon1 in the 13th century. It is interesting how much still holds true 7 centuries later:

There are in fact four very significant stumbling blocks in the way of grasping the truth which hinder every man, however learned, and scarcely allow anyone to win a clear title to wisdom; namely, the example of weak and unworthy authority, long-standing custom, the feeling of the ignorant crowd, and the hiding of our own ignorance while making a display for our apparent knowledge.

Every man is involved in these things, every rank is affected. For every person, in whatever walk of life, both in application to study and in all forms of occupation, arrives the same conclusion by the three worst arguments; namely, this is a pattern set by our elders, this is the custom, and this is the popular belief. Therefore it should be held.

Anthony P.C. Yim, BM, BCh, FCCP, Division of Cardiothoracic Surgery, Department of Surgery, The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, N.T., Hong Kong

REFERENCES


Bronchiectasis in an Aging Cohort

To the Editor:

Our observations on the clinical and radiographic features of patients with adult-onset bronchiectasis (AOB) are remarkably similar to those described by Nicotra and colleagues (CHEST 1985; 108:955-61). In my registry of previously well patients with AOB, all were female (binomial p=0.031), the mean age at onset of symptoms of bronchiectasis was 44 (range, 28-62), and 1 of 5 smoked. Each patient recalled an inciting lower respiratory infection (LRI): in one, it was insidious; in three, acute; and in the fifth, life-threatening. The character of the illness—copious purulent sputum production, accompanied by brisk leukocytosis—suggested a bacterial cause. In none, however, was the etiologic agent identified. There was a latent period of 4 to 5 years in 3 of the 5 patients.

Because of the age of onset and prior good health of these patients, a clinically invidious underlying genetic or immunologic defect was not assiduously sought. We too found high-resolution CT unnecessary for confirmation when characteristic clinical and radiographic features of bronchiectasis were evident. We found augmentation of rales and end-inspiratory rhonchi by a posttussive maneuver performed at end-expiration to be a helpful diagnostic feature.

Erythromycin was used as the sole initial antibiotic treatment of the inciting LRI in four patients; in the fifth patient, who was hospitalized for treatment of an overwhelming pneumonia, it was employed in combination with a third-generation cephalosporin. One third of patients with LRI treated at Kaiser Permanente, Northwest Region, during the period in which these patients were seen, received erythromycin as initial therapy (data on outpatient antibiotic utilization were derived from the Outpatient Utilization Database, maintained by the Center for Health Research, Kaiser Permanente, Northwest Region). Under the assumption that this figure represents the practice pattern of the medical community at large, the probability that this association arose by chance is small (binomial p=0.004).

We wondered whether the authors or others with an interest in bronchiectasis had or could acquire information about initial therapy of the inciting LRI in their patients. The association we observed in this small cohort of patients with AOB led us to postulate that erythromycin, perhaps as a consequence of its limited antibacterial spectrum and low intrabronchial concentration,1 may have played a permissive role in its genesis.2

Jerome M. Reich, MD, FCCP, Division of Pulmonary Disease, Center for Health Research, Kaiser Permanente, NW Region, Portland, Oregon

REFERENCES


Determination of Post-Salbutamol Methacholine Dose Shift

To the Editor:

The functional antagonist or bronchoprotective effect of an inhaled β2-agonist can be determined by measuring the methacholine PC20 before and after a standardized dose of the drug. The customary procedure has been to perform the two measurements of methacholine PC20 on separate days.1,2 We have found it more convenient to measure the methacholine PC20 before and after inhaled β2-agonist on the same day.3,4 The following brief investigation is presented in response to questions regarding the validation of this same-day methodology.

We studied 15 well-controlled asthmatics who were able to withhold inhaled β2-agonists for more than 2 weeks. These subjects were studied outside of any relevant allergen exposure and had not had a respiratory tract infection for at least 4 weeks. They attended the lab on two occasions at the same time of day within a 1-week period. On one day, the subjects underwent a standardized methacholine challenge5 10 min following administration of 2 puffs of salbutamol from a metered-dose inhaler. On the other day, the post-salbutamol methacholine PC20 was preceded by an unmedicated methacholine challenge. On this occasion, as in our previous studies,3,4 the methacholine PC20 was determined (no rescue medication was administered) and 50 min after the completion of