of your colleagues (or everyone in the American College of Chest Physicians) at the touch of a button, without the need or cost of photocopying and mailing the information. In addition, when you annotate your lectures or reference the articles in CHEST, you could give the location where the article exists electronically and print it via the Web browser if you need hard copy for the bathroom.

Reviewers, readers, editors, etc, with appropriate security, would have easy access to submitted and reviewed journal articles, as well as a way to access status reports on the review process. Articles would be immediately available to reviewers, and you would have an electronic means to know who “picked up” the article from the website but has not submitted it back with appropriate comments. All your reviewers need to be online! The idea is not just to speed up the review process, but to create a process that is quantifiable to improve the organization. The Web language, hypertext mark-up language (HTML) (a subset of standard generalized mark-up language [SGML]), was created to manage documents. I see this as a primary business process of CHEST. Access to this service would be by subscription just like your journal is now. Personally, I would rather get an email each month with the table of contents and electronic links to the articles I want. This would allow me to set up my preferences regarding the articles I want to read by keyword or category, and your organization would save the cost of printing and mailing the journal. You could reduce the subscription rate for electronic users and save a few trees.

Perhaps you should consider spending some time on the electronic version of the Wall Street Journal (http://www.wsj.com), PC Week (http://www.pcweek.com), or ChestNet (http://www.chestnet.org) to see the power of electronic publishing.

Hope to count you as one of the enlightened and converted by the time your next editorial in CHEST on the Web comes up.

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REFERENCE

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A Complete World Wide Web Without CHEST?

To the Editor:

Evidence-based medicine has become the established standard for practitioners of what we call “modern medicine.”1 Intuition, anecdotes, “common sense,” and clinical experience can no longer serve as the cognitive building blocks for clinical decision making.2 Every decision that the clinician makes must be based on sound scientific data (a collection of anecdotes is not scientific data).1,3 Yet, how does the busy physician rapidly and efficiently obtain the information needed to make an informed clinical decision? Most medical textbooks are out of date before they even reach the printing press and rarely provide the information one needs. Furthermore, most physicians are too busy to spend time dabbling in a medical library.

The Internet, and in particular, the World Wide Web (WWW), has become the axonal conduit to this wealth of information.4 Online, up-to-date, and searchable texts will replace the printed textbook in the very near future.5 The clinician will be able to search rapidly for, and download journal articles in the office. The paradigm will shift even further in that clinicians will be able to subscribe to “Internet Journal Services,” much like news services, which will automatically search the world literature and download (daily/weekly) those journal articles of direct relevance to the clinician.

How do the highly reputable medical journals ride this new wave of technology? The primary function of these journals is to communicate high-quality, peer-reviewed information to the members of the medical community so that they can apply and relay this information to their patients. While the quality of CHEST and others like it is indisputable, these journals have failed to effectively reach physicians on all corners of the earth. In many foreign countries, it takes months for the current edition of a journal to arrive, and it often gets lost in the mail. Furthermore, economic realities in many countries limit the number of journals that a physician can subscribe to.

The WWW provides the means to disseminate medical information without delay to our medical colleagues throughout the world.4,5 In addition, it will be possible to publish a journal simultaneously in a number of languages. After all, is not the goal of CHEST and others like it to empower all physicians with information? Furthermore, we need not restrict this information to physicians, but to all who may benefit from it.

The WWW provides a unique opportunity for CHEST to offer the industry multimedia advertisements. A picture is worth a thousand words, and add to that the power of speech and video. The increased audience will enable CHEST to charge a low access fee. For the computer illiterate physician, who will soon face extinction, CHEST could be published both on the Internet and in print.

Rather than jeopardizing the accuracy of the peer-review and editing process, the Internet-based journal offers the opportunity for improving the editorial process. Surprisingly, many of the journal articles published in highly reputable peer-reviewed journals take up to a year from first submission to publication. This is highly inefficient. Manuscripts can be submitted by email, edited online, and then published.1,4

The information superhighway is here to stay. We need to embrace it and tap its full potential. In response to your editorial (June 1997),1 we say that publications like CHEST must be available online for access by health-care providers around the world.

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REFERENCES

Pneumonitis Due to Mycobacterium avium Complex in Hot Tub Water

Infection or Hypersensitivity?

To the Editor:

We read with interest the paper by Embil et al (March 1997) because their first case resembled a patient we recently described in CHEST (January 1997). In our case, there was no doubt that we were dealing with an infection acquired from a hot tub. The patient's condition deteriorated despite discontinuation of the use of the hot tub, and dramatically improved after appropriate antimycobacterial therapy. Cultures of the lung tissue yielded Mycobacterium avium, which was shown by restriction fragment length polymorphism testing to be identical to the organism isolated from the hot tub water.

Embil et al favor a diagnosis of hypersensitivity pneumonitis based on the history, lung biopsy histology, and spontaneous recovery. However, there was no serologic proof of an immunologic reaction to M avium, and the microscopic features they describe and illustrate indicate mycobacterial infection rather than hypersensitivity pneumonitis. The pathologic diagnosis of hypersensitivity pneumonitis is based on the identification of patchy, nonspecific interstitial pneumonia with peribronchiolar accentuation, non-necrotizing granulomas and/or epithelioid histiocytes, and foci of bronchiolitis obliterans combined with the exclusion of infection. Figures 2 and 3 in their report show well-defined granulomas, whereas the lesions in hypersensitivity pneumonitis are described as “loosely formed and poorly circumscripted.” The identification of mycobacteria in histologic sections indicates invasion and multiplication of microorganisms in the tissue, which establishes this as an infection rather than an immunologic reaction. If nontuberculous mycobacteria could, in fact, cause hypersensitivity pneumonitis, it is strange not to have had previous examples, considering their ubiquitous presence.

The recovery, with little or no treatment, in this patient and the other cases reported by Embil et al, is unusual for M avium infection. The normal immunity of the patients may have played a part, and the condition may be analogous to primary infection in tuberculosis, in which the door is shut on further progression by the development of cell-mediated immunity, exemplified by the presence of granulomas.

We agree with Embil et al that the cases we have described point to the need for caution in the use of hot tubs.

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References


To the Editor:

We acknowledge the points that Kahana and Kay make in their letter. However, we are unable to be as confident as to what was occurring in the patients we reported as they were in their case report, hence, our title “Hypersensitivity pneumonitis or infection?” Despite effort, we were unable to produce an adequate Mycobacterium avium complex (MAC) antigen for serologic testing and so we could not confirm immune reaction to MAC. On the other hand, lack of serology has not refuted the diagnosis of hypersensitivity pneumonitis in other reports. The editorial by two experienced workers in the field thought our suggestion of hypersensitivity pneumonitis to be plausible. Despite the different approaches and conclusions, each of these papers poses an intriguing aspect of the illness associated with MAC. Both are very different from the traditional disease described with MAC. We believe that our interpretation is most compatible with the discussion in the clinical pathologic exercise reported in 1996, which left the participants with the dilemma of infection or hypersensitivity. After all, the immune reactions of the lung which protect and those that may produce hypersensitivity are two faces of the same coin.

The basis for the suggestion of hypersensitivity pneumonitis is supported by the observation that cases 1 and 2 had symptoms over a period of months, with the former relapsing on further exposure to the hot tub and the latter acutely worsening on heavy exposure. This is very suggestive of a hypersensitivity reaction. In their letter, Kahana and Kay make much of the interpretation of the histology in our case—as they know it is as yet hard to be dogmatic in this area, since a range of findings have been reported in hypersensitivity pneumonitis. In Farmer’s Lung, organisms, admittedly spores, are seen in the biopsy—we are unable to judge multiplication of the MAC organism in the lung on our biopsy. If these cases were infections, presumably they were analogous to primary infection, and the widespread nature of the lesions was due to the dispersal of the inoculum. Or, alternatively, if an infection was smoldering in the lungs of cases 1 and 2, were the exacerbations of symptoms with further exposure to the hot tubs due to further infection or an immune response, hypersensitivity, to a new exposure?

We agree with Kahana and Kay that considering the ubiquitous presence of MAC, it is strange not to have previous examples of hypersensitivity pneumonitis, but this also applies to infections with M avium such as they describe. In other studies of humidifier lung syndrome, there is little evidence that mycobacteria have been sought. It is unusual for such a case as described by Kahana and Kay to be so exceptionally responsive to treatment, particularly when the organism was resistant in vitro to the therapy that was initially selected, in an infection that had progressed. Was an immune reaction contributing to the disorder and symptoms? Clearly, the two papers raise more questions than answers. Could the responses that were observed be due to differing virulence of the MAC isolated, the magnitude of the