Drs. Redman and Druce infer from their survey data that inhaled epinephrine self-treatment is limited to mild asthma only. We do not come to the same conclusion on the basis of our own data from two independent studies or, indeed, on the basis of the data that they themselves provide: 24% of those that they surveyed required urgent care for their asthma during the prior year; of these, more than a third appeared to have quite poorly controlled disease, which led to frequent urgent care visits. Data on hospitalization and on therapies that would serve as markers of more severe disease (e.g., systemic corticosteroid administration) were not provided. Perhaps most importantly, survey data examining delays in the institution of more specific sympathomimetic medication as well as anti-inflammatory therapy, although of considerable interest, remain to be reported.

Ware Kuschner, MD
Division of Respiratory and Critical Care Medicine
Stanford University School of Medicine
Veterans Affairs Palo Alto Health Care System
Palo Alto, California

Paul D. Blanc, MD, MSPH, FCCP
Division of Occupational and Environmental Medicine and
Division of Respiratory and Critical Care Medicine
University of California, San Francisco

REFERENCES

Significance of Airway Colonization by Burkholderia gladioli in Lung Transplant Candidates

To the Editor:

We read with interest the article by Kanj and colleagues in CHEST (October 1997)1 on the role of airway colonization by multidrug-resistant organisms in causing invasive infection following lung transplantation in patients with cystic fibrosis (CF). The authors report two cases of lung transplant recipients who developed bacteremia and sternal wound infection by Burkholderia gladioli and mention that these were the first reported cases of B gladioli infection in human lung transplant recipients. They also suggest that infection with B gladioli at the time of pretransplant evaluation should not be considered a contraindication to transplantation. We want to point out that we recently reported a case2 of a 25-year-old lung transplant recipient with CF who developed recurrent chest wall abscesses and empyema from B gladioli infection. In contrast to the patients reported by Kanj and colleagues, our patient had a progressive, deteriorating course, and despite appropriate antibiotic therapy, eventually died from widespread infection.

Although earlier reports suggest that B gladioli is a benign colonizer in CF patients,2,3 its pathogenicity in an immunocompromised host should not be underestimated. We recommend a cautious approach in selecting patients for lung transplant evaluation if their pretransplant evaluation shows airway colonization by B gladioli.

Saeed U. Khan, MD
Alejandro C. Arroliga, MD
Department of Pulmonary and Critical Care Medicine
Steven M. Gordon, MD
Department of Infectious Diseases
The Cleveland Clinic Foundation
Cleveland

REFERENCES

Parapneumonic Effusion Does Not Equal Empyema

To the Editor:

The randomized trial of empyema therapy published recently in CHEST (June 1997)1 is an important first step in attempting to introduce science into the study of empyema and parapneumonic effusions. The authors chose an unfortunate title for their study, however, since most clinicians would label their cases as parapneumonic effusions, rather than empyema.

Although the definition of empyema is controversial, Light prefers "thick, purulent-appearing pleural fluid."2 Indeed, most clinicians think of empymema as a thick, soupy material in the pleural space—often resembling pea soup—with many WBCs and associated with a high percentage of positive Gram’s stains and cultures. This soupy material is incompatible with the blood gas machines generally used to measure pH, so this study on pH of the pleural fluid is clearly of parapneumonic effusions and not of empymema.3

While pH is well known to decline with more aggressive infections, the 7.20±0.12 pH range of Wait et al’s video-assisted thoracoscopic surgery group is not sufficiently low to warrant invasive treatment, in general. Similarly, their chest tube/streptokinase group had a pH of 7.26±0.15. The fact that half of these patients failed drainage with #36 chest tubes plus streptokinase is of interest and is difficult to understand. Radiographic shadows do, however, often increase due to pleural reaction in this context while the WBC and fever are declining.

I have been treating this kind of patient for many years with antibiotics and repeated thoracostesis, using a #14 F catheter, and very rarely have I resorted to tube thoracostomy or any surgical procedure;4 most of these patients were discharged on oral antibiotics, returned to work, and were clinically well, although some required several months for the radiograph to normalize.

As the authors mentioned in their discussion, “it is difficult to recommend one type of treatment as routine” because of the diversity of the patients. However, their data is consistent with a