near-complete regression of pulmonary hypertension, although this hypothesis would need to be tested in a prospective trial. How long had nifedipine been discontinued in the authors’ patient prior to repeat cardiac catheterization? How long has the patient’s exercise tolerance remained dramatically improved since the discontinuation of vasodilators?

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REFERENCES

Self-Inflicted Intramyocardial Injury

To the Editor:

Jamila and Casey, in their report “Self-Inflicted Intramyocardial Injury With a Sewing Needle” (February, 1998)1 mention that there has been only one reported case of pneumomarx resulting from self-injury with a needle.2 That case of self-induced pneumomorax was actually preceded by almost 50 years by the ruse perpetrated by French physicians on their German captors in early World War II. The prevailing opinion through the 1930s was that pulmonary tuberculosis was the primary cause of pneumomorax. The French physicians surreptitiously induced "iatrogenic" pneumomorax with needles, causing pneumomorax which the Germans assumed to be caused by tuberculosis, and therefore repatriated them back to their homeland.3

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REFERENCES

Misreading of the Tuberculin Skin Test

To the Editor:

I read with great interest the recent article by Kendig and colleagues (May 1998),1 as well as the accompanying editorial by Reichman (May 1998).2 I certainly agree with their findings that there is a high level of inaccuracy in the interpretation of tuberculin skin tests.

I was raised in East Africa, and in my early childhood received a Bacillus Calmette-Guérin (BCG) vaccination. As one would expect, my purified protein derivative (PPD) skin test has always been positive. When I went through my medical examination for entry into the US, I had a skin test that was interpreted by the examiner as being >10 mm. Many years later another PPD was applied, and I interpreted the study as showing 19 mm of induration. The surrounding erythema produced a circle of 23 mm in diameter. My chest roentgenogram was normal.

At the time I was an Assistant Professor of medicine in the department of pulmonary medicine at a major university teaching hospital. I took the opportunity of asking 36 of my fellow academicians, fellows, internal medicine residents, clinic nurses, and medical students to interpret my skin test. I was impressed by the diversity of opinion as to whether the test was even positive or negative. The distribution of results ranged between 0 mm of induration up to 22 mm (Figure 1). I did not get the impression that the study was underread, but rather concluded that very few people could interpret the study correctly.

My conclusion was that if it is indeed important to know the result of a patient’s PPD, I would need to read the study myself. To rely on others carries the same risks inherent in relying on another individual’s interpretation of any medical investigation, such as pulmonary function studies, chest roentgenograms, and sleep studies. We unfortunately have to rely too much on others to make important measurements for us. Temperatures, fluid intake and output, blood pressures, and even daily weights are excellent examples of measurements that we use constantly to make critical treatment decisions, and in which the room for error is large.

The recent article by Kendig and colleagues1 serves a very useful reminder of the adage that “...if a job is worth doing, it’s worth doing oneself.” The tuberculin skin test is too important a test to leave to the whims of the uninstructed. I agree with Reichman2 that to ignore the findings of this study, “...would be the height of irresponsibility.”

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