technique is a mistake, considering that it is being used increasingly in pediatric patients in the United States, Australia, and Europe, with much success.

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Comparison of Oxygenation in Patients Staying in Dead Sea or in Jerusalem

To the Editor:

We read with interest the article by Kramer and colleagues in the March 1998 issue of CHEST. The data provided in the paper demonstrate an impressive improvement in oxygenation of hypoxic COPD patients while staying in the Dead Sea area as compared to Jerusalem, even though the changes in barometric pressure, and hence, in inspired oxygen pressure, were only in the range of 100 and 21 mm Hg, respectively. The mechanisms, which could account for such an improvement in oxygenation, remain speculative, and we would like to suggest the following comments to this interesting report: 1. The ambient temperature, even though this was not indicated in the paper, is known to be quite different in the warm Dead Sea area as compared to Jerusalem. The difference, depending on the season, may exceed 10°C. It is known that in small mammals, relative low ambient temperature and hypoxia may markedly affect gas exchanges, including oxygen consumption.2 It follows that the higher ambient temperature of the Dead Sea area as compared to Jerusalem, in addition to the higher inspired oxygen pressure, may have influenced gas exchanges in the patient resulting in a better oxygenation. 2. Again, it has been shown that in animals exposed to hypobaric hypoxia as compared to normobaric hypoxia, the breathing pattern may differ with a significantly lower breathing frequency in the case of normobaric hypoxia.3 If these results, which demonstrate an effect of barometric pressure pO2 on breathing pattern, are extrapolated with caution to the results of Kramer and colleagues,1 it may well be that the breathing pattern (tidal volume, breathing frequency), and hence, gas...
The results are usually expressed as the provocative concentration or dose producing a 20% fall in FEV₁ (PC_{20} or PD_{20}), by interpolation of the last two data points on the log dose-response curve. It is uncertain how to best approximate the PC_{20} when the test is stopped before a 20% FEV₁ fall has been achieved. One method is the extrapolation of PC_{20} from the last data point alone. Another method is to extrapolate the PC_{20} from the last two data points, as in the interpolation formula. We compared these two ways of estimating PC_{20} with the interpolation by formula in a retrospective analysis of 100 methacholine or histamine bronchial challenge tests using the

**Methacholine PC_{20} Extrapolation**

To the Editor:

I was delighted to see that a couple of your readers\textsuperscript{1,2} challenged, as I did,\textsuperscript{3} Kubba and Young,\textsuperscript{4} who attributed Chopin’s illness to α_{1}-antitrypsin deficiency, instead of tuberculosis, which was really what Chopin had and died of.

In reply to my letter,\textsuperscript{3} Kubba\textsuperscript{5} stated that “in an age when consumptive patients were committed to isolation homes, it seems unusual for Chopin, if he was thought to be consumptive, to have been cared for in the community.” Your readers might be interested in a quote from George Sand in René and Jean Dubos’ book, *The White Plague*. In Chapter 4, there are quotes from both Chopin and Sand from their stay in Majorca, Spain. Chopin’s statement refers to his hemoptysis, while Sand describes Majorca as a “magnificent country but most inhospitable.” The natives rightly believed consumption to be contagious! Furthermore, the sanatorium movement had not really gotten a good start by 1837 when Chopin died; “fingers” wandered around their homes and neighborhoods as they were able.

In the Nineteenth Century, it was either syphilis or tuberculosis that seemed to carry off so many geniuses. In Chopin’s case it was tuberculosis that stilled those fingers at the youthful age of 39.\textsuperscript{7}

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**Figure 1.** Comparison of conventional PC_{20} and PC_{20} estimated by two methods of linear extrapolation.