Bronchorrhea in bronchioloalveolar carcinoma, and blockade of COX-2 seems effective in the treatment of this condition.

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To the Editor:

The comments by Tamaoki and coworkers on our article (CHEST; May 1999)1 show the importance of the expression of COX-2 messenger RNA in carcinoma cells. The results are very useful in establishing treatment with inhaled indomethacin for bronchorrhea in patients with bronchioloalveolar carcinoma. Tamaoki and colleagues demonstrated the theoretical reason why there are two groups of bronchioloalveolar carcinoma patients: one group that is responsive to inhaled indomethacin and the other group that is not responsive.

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Reference


A Role for Anaerobic Bacteria in Patients With Ventilatory Acquired Pneumonia

Yes or No?

To the Editor:

We read with great interest the article of Marik and Careau (CHEST; January 1999).1 Despite specific care (rapid transport, adequate transport medium, and inoculation onto specific media...
under anaerobic conditions), only one anaerobic bacterium was isolated in this study, leading to the conclusion that anaerobic bacteria were not likely to be involved in these infections and that antibiotics effective against anaerobic bacteria may not be useful as empiric treatment in these situations. However, it is well known that the concentration of anaerobic bacteria in the oropharynx is higher than that of aerobic bacteria. These bacteria colonizing the oropharynx are responsible for nosocomial pneumonia. Thus the inability to isolate anaerobic bacteria in this study is surprising. Using specific transport and culture conditions, we could isolate a high percentage of anaerobic strains from protected brush specimens (PSB) in patients with ventilator-acquired pneumonia (VAP). These striking differences between the results of Marik and Careau and ours may be related to technical differences in the laboratory procedures used to recover anaerobic bacteria from PSB. First, we used freshly prepared meat yeast VL agar medium (Sanofi Pasteur; Marnes La Coquette, France) for anaerobic culture. This medium is prepared twice each week and is complemented with 8% sheep blood, menadione, and gentamicin, making this medium selective for anaerobes. Secondly, the anaerobic atmosphere was obtained in an oxoid jar with the Anaerogen Oxoid system (Oxoid; Basingstoke, England), which gives us better results than other tested systems (unpublished data). Finally, 2 of the 20 technicians in our laboratory are specifically assigned to the anaerobic bacteria department because of their skill in studying these bacteria.

Nevertheless, the potential interest of using antibiotics effective against anaerobic bacteria in patients with nosocomial pneumonia remains controversial.3 We recently reported that patients with VAP receiving well-adapted empiric antibiotic therapy against anaerobic bacteria had a better outcome at D10.7 Furthermore, in a recent large study comparing the efficacy of ceftazidime vs piperacillin-tazobactam in ICU patients with VAP, mortality was lower in patients receiving piperacillin-tazobactam than in those receiving ceftazidime.5 Although anaerobic bacteria were not specifically investigated in this study, we can speculate that the mortality difference might be explained in part by a better activity of piperacillin-tazobactam than ceftazidime on anaerobes, which could have been associated with aerobic bacteria in patients with VAP.

In conclusion, because anaerobic bacteria are numerous in the oropharynx, and because colonized oropharyngeal content leads to nosocomial pneumonia, anaerobes associated with aerobic bacteria should be isolated in patients with VAP or aspiration pneumonia. Furthermore several arguments suggest taking into account these bacteria in the choice of empiric antibiotic therapy in patients with VAP.

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A Possible Pathologic Link Between Chronic Cough and Sleep Apnea Syndrome Through Gastroesophageal Reflux Disease in Older People

To the Editor:

In a recent issue of CHEST (August 1999), Palombini and colleagues1 reported that asthma, postnasal drip syndrome (PNDS), and gastroesophageal reflux disease (GERD), alone or in combination, were responsible for >90% of the causes of chronic cough. They proposed that asthma, PNDS, and GERD should be called a pathologic triad in chronic cough.1 Because cough is the most common symptom for which adult patients seek medical attention from primary care physicians, and because cough is associated with deterioration in patients’ quality of life,2 the study of Palombini et al is very important, not only for assessing chronic cough, but also for determining therapeutic strategies for patients with chronic cough.1,3

However, in older patients, the causes of chronic cough may be more complicated. Age-related changes in cough reflex may affect the causes and therapeutic efficacy of chronic cough.4–6 Further, the protective role of cough as the defense mechanism of aspiration is very important for the pathogenesis of chronic cough in older patients.7–9 We have recently reported that gastroesophageal reflux (GER) is frequently found in obstructive sleep apnea syndrome (OSAS) in the elderly.10 Indeed, many patients with OSAS complain of sleep-related heartburn and regurgitation of gastric contents into the pharynx.11 It has been reported that treatment with nasal continuous positive airway pressure at night can correct the sleep apnea-related GER in patients with OSAS.12 We have also reported that the swallowing reflex is impaired in patients with OSAS,13 suggesting that OSAS may perturb the inspiratory-expiratory transition during deglutition in the patients. Because OSAS and GER may aggravate bronchial asthma, it is more difficult to control asthma in such patients.14,15 In these patients, treatment with nasal continuous positive airway pressure at night is sometimes reported to improve control of asthma.14,15 These observations indicate that OSAS may be a cause of chronic cough through GERD in the elderly. Because GERD manifests a spectrum of conditions, including asthma, posterior laryngitis, and chronic coughing, the cause of GERD is not always simply determined in older people.

Owing to the explosive growth of the older population, we are seeing many more elderly patients with pulmonary disease. Because the incidence of OSAS increases with age, a possible pathologic link

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