Dissecting Aortic Aneurysm

To the Editor:

Little and coworkers (November 1999), refer to a dissecting aortic aneurysm “thought to be due to a congenitally bicuspid aortic valve.” Since the etiopathogenesis of aortic dissection in this context is not understood, the relationship to bicuspid aortic valve should be regarded as associative rather than as primarily causative.

It is noted that the surgical procedure employed was described initially by Hugh Bentall, not “Bentol” as stated in the article.

H. Alexander Heggtveit, MD
McMaster University
Hamilton, Ontario, Canada

REFERENCES

To the Editor:

Benjamin Franklin once said, “Our critics are our friends, for they show us our faults.” In this spirit, we would like to thank Dr. Heggtveit for pointing out our slippiness. We regret misspelling the procedure that is named after Dr. Hugh Bentall. As well, we fully accept that, whereas the association of a congenitally bicuspid aortic valve and an ascending aortic aneurysm with a risk of dissection is well described, our initial statement did erroneously imply a higher certainty of causation than is justified.

Sanjay Mehta, MD
London Health Sciences Centre
London, Ontario

Persistent Presence of Acid-Fast Bacilli in Pulmonary Tuberculosis

Possible Implications for Developing Countries

To the Editor:

I went carefully through the study, “The Significance of the Persistent Presence of Acid-fast Bacilli in Sputum Smears in Pulmonary Tuberculosis” by Al-Moamary et al (September 1999). They have correctly pointed out the fact that while their recommendations may apply well to developed countries, it may not be the case for other developing countries, where the incidence of initial as well as acquired drug resistance is relatively high.

In a country like India, the facility of a standard laboratory for Mycobacterium tuberculosis culture and sensitivity is far from the reach of the general population. Furthermore, the concept of directly observed treatments has not yet been applied to the wider part of the nation to ensure compliance to treatment. With this background, one can afford to go for culture and sensitivity tests only when treatment failure is suspected on the basis of smear positivity at the end of 20 weeks of treatment, as recommended by World Health Organization (WHO) criteria.

The purpose of my communication is to share my preliminary data (unpublished) from a study of multidrug-resistant tuberculosis (MDR-TB), which is going on at Jawahar Lal Nehru Medical College, in Ajmer, India. On the basis of smear positivity at 20 weeks of treatment with first-line antituberculous drugs, sputa of 26 patients were subjected to culture and sensitivity tests for antituberculous drugs. Twenty-four patients (92%) had positive culture after 4 to 8 weeks of incubation. All of them were resistant to isoniazid and rifampicin, with variable resistance to other antituberculous drugs. Sixteen patients (67%) had moderate to advanced parenchymal disease.

On the basis of the above data (although small), I have my submission for developing countries in the same context: (1) All patients with smear-positive cultures after 20 weeks of treatment with first-line drugs should strongly be suspected as having MDR-TB and must undergo culture and sensitivity tests; and (2) There are more chances of treatment failure with more extensive parenchymal diseases in contrast to the above-mentioned study.

In the last, I have two important queries to the authors regarding the interpretation of their study results.