BeIA and p50 in airway cells with or without EIA transfection, LPS could induce nuclear translocation of NF-κB in EIA-transfected cells alone. In EIA-transformed airway cells, the NF-κB transcription factor is involved in the IL-8 gene and ICAM-1 gene expression after LPS stimulation. In addition, Metcalf reported that adenovirus E1A 13S gene product up-regulates TNF-α gene. On the other hand, cigarette smokers have increased numbers of neutrophils present in their lower respiratory tract. Acute exposure to cigarette smoke induces infiltration of neutrophils into the airways through NF-κB and IL-8 gene expression. Consequently, the latent adenovirus infection and cigarette smoke synergistically cause chronic airway inflammation through the cytokine genes and adhesion molecule genes expression, possibly via NF-κB activation. Thus, NF-κB activation may be involved in the pathogenesis of COPD and chronic airway inflammation after chronic cigarette smoke inhalation and adenovirus infection. These experimental data should be further confirmed in the future by clinical data in humans.

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Chicken Soup or Jewish Medicine

To the Editor:

The study by Rennard et al (October 2000) is the latest attempt at humor on the subject of chicken soup, but it leaves a bad taste in one’s mouth with regard to the millennia-old discipline of Jewish Medicine. Ancient Jewish literature included descriptions of folk remedies, even the “Dreckapotheke,” medicines that were derived from offensive human and animal parts and excretions (I place the swiriling of dead chicken remains in vegetable broth in this category). However, in keeping with respect for educated scientific and medical opinion, Jewish sages throughout the ages have warned that one should not rely on the folk remedies of the Talmud, and some have even stated that it is forbidden to do so.

Rennard et al mention that chicken soup has been referred to as Jewish penicillin, and I have no doubt that it is just as effective as any antibiotic in the treatment of viral illnesses. But instead of trying to inhibit the function of WBCs to control inflammation, which could be harmful, we should be trying to bolster the immune system to eradicate the infection and prevent complications.

Aside from his medieval remedies such as chicken soup, what did Maimonides feel was the main focus of medicine? The story is told that the Sultan of Egypt asked Maimonides, who was his physician, “How do I know you’re such a great physician? After all, in all the time you’ve been taking care of me, I’ve never been sick.” Maimonides replied that in the Bible (Exodus 15:26), God promised the children of Israel that if they followed all of His commandments, He would protect them from all of the diseases they had placed on the Egyptians, concluding, “I am the Lord your physician.” Because, in preventing illness, we are emulating God, prevention is the highest form of healing, and preventing illness is the main role of a physician. Maimonides explained that when a patient follows his physician’s advice on lifestyle (diet and exercise) and the patient does not get sick, that is the greatest proof of a physician’s abilities. And that is what Jewish Medicine is really all about.

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Etiology of Community-Acquired Pneumonia Requiring Hospitalization in Japan

To the Editor:

Community-acquired pneumonia (CAP) remains a common cause of morbidity. Because CAP also is a potentially fatal disease, even in previously healthy persons, early appropriate antibiotic treatment is vital. In Japan, pneumonia is the fourth leading cause of death, and from 57 to 70 persons per 100,000 population died per year of this disease in the last decade. Because of this high rate of morbidity, guidelines for CAP management have been produced in Japan. However, prospective studies on the etiology of CAP among the Japanese population have been very limited, and only the etiology of CAP has been investigated by Ishida et al (December 1998). Therefore, we investigated the etiology of CAP requiring hospitalization in Japan based on our findings.

We undertook a study to determine the etiology of CAP in

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Japan between April 1998 and September 2000 at three different hospitals. The microbiological and serologic studies that were performed were almost the same as those used in the study by Ishida et al. In addition, we also employed other diagnostic methods for the detection of Chlamydia spp, Coxiella burnetii, and Legionella spp. Chlamydia pneumoniae, Chlamydia psittaci, and Chlamydia trachomatis infections were diagnosed by isolation in cell cultures and by serology. Antibodies to Chlamydia spp were measured by the microimmunofluorescence test, and cell cultures were performed in cycloheximide-treated HEp-2 and HeLa 229 cells. Antibodies to C. burnetii were measured by the indirect immunofluorescence test. In addition to serology and culturing, the urinary antigen test was used for detection of Legionella spp.

Two hundred patients (128 men and 72 women; age range, 19 to 91 years; mean age, 60.9 years) who had had episodes of pneumonia were enrolled in the study. One hundred nine (54.5%) patients had at least one underlying disease. A microbiological diagnosis was established in 117 patients with pneumonia (58.5%). The most common pathogens were Streptococcus pneumoniae (41 patients [20.5%]), followed by Haemophilus influenzae (22 patients [11.0%]), Mycoplasma pneumoniae (19 patients [9.5%]), C. pneumoniae (15 patients [7.5%]), and Staphylococcus aureus (10 patients [5.0%]) (Table 1). Dual pathogens were detected in 25 patients (12.5%). Ishida et al investigated the etiology of CAP among the Japanese population for the first time, and their findings did not differ markedly when compared with those of Western countries. Our results were almost consistent with those of Ishida et al., with the exception of the frequencies of atypical pathogens. The frequencies of atypical pathogens, C. pneumoniae, Legionella spp, C. burnetii, and M. pneumoniae, have been recognized as common respiratory pathogens. In several studies, these organisms have been found to account for up to 25% of CAP cases in Western countries. In the present study, we were able to detect atypical pathogens in approximately 20% of CAP cases. The frequencies were lower than those in Western countries but were higher than those in the study of Ishida et al. The difference from the study by Ishida et al may be related to the period in which the survey was conducted or to the traditional diagnostic methods used for the detection of C. pneumoniae.

In our study, S. pneumoniae was the leading cause of CAP, and an emerging or newly recognized pathogen, C. pneumoniae, was also a significant causative microorganism in Japan. The recognition of these results will allow us to treat patients with prompt antimicrobial therapy and will promote the formulation of new guidelines for the management of CAP in Japan.

Table 1—Microbiological Diagnosis of 200 Episodes of CAP

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>S. pneumoniae</td>
<td>41</td>
<td>20.5</td>
</tr>
<tr>
<td>H. influenzae</td>
<td>22</td>
<td>11.0</td>
</tr>
<tr>
<td>M. pneumoniae</td>
<td>19</td>
<td>9.5</td>
</tr>
<tr>
<td>C. pneumoniae</td>
<td>15</td>
<td>7.5</td>
</tr>
<tr>
<td>S. aureus</td>
<td>10</td>
<td>5.0</td>
</tr>
<tr>
<td>Anaerobes</td>
<td>8</td>
<td>4.0</td>
</tr>
<tr>
<td>Viruses</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Moraxella catharrhalis</td>
<td>6</td>
<td>3.0</td>
</tr>
<tr>
<td>Klebsiella pneumoniae</td>
<td>5</td>
<td>2.5</td>
</tr>
<tr>
<td>Pseudomonas aeruginosa</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Streptococcus milleri group</td>
<td>4</td>
<td>2.0</td>
</tr>
<tr>
<td>Legionella pneumophila</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>C. psittaci</td>
<td>2</td>
<td>1.0</td>
</tr>
<tr>
<td>C. burnetii</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Unknown</td>
<td>83</td>
<td>41.5</td>
</tr>
</tbody>
</table>

*Patients with dual infections were included.

References