onset asthma has received less attention. However, the relationship between ETS exposure and adult asthma prevalence could be explained by the well-known relation between ETS exposure and childhood asthma. As the authors point out, the effect of ETS exposure on asthma could reflect onset of asthma during adulthood. Without knowing the age of asthma onset, the study does not clearly advance our understanding of how childhood ETS exposure affects the onset of asthma during adulthood.

The study of Larsson et al contributes to the literature linking ETS exposure with a greater risk of asthma. Unfortunately, the study does not clearly advance our understanding of how childhood ETS exposure affects the onset of asthma during adulthood. The study presents two alternate definitions of asthma, both of which measure lifetime prevalence of asthma. In other words, the prevalence of ever having asthma or having a physician diagnosis of asthma could reflect onset of asthma during childhood or adulthood. Without knowing the age of asthma onset, the observed association between childhood ETS exposure and adult asthma prevalence could be explained by the well-known relation between ETS exposure and childhood asthma.

Based on the available epidemiologic literature and strong biologic plausibility, ETS exposure is a likely cause of adult-onset asthma. To better define this relationship, future studies should evaluate incident, rather than prevalent, adult asthma cases.

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REFERENCES

Workup Following Tissue Expectoration

To the Editor:

The article by Kelly et al (February 1999) was of interest to us. The most common causes of expectoration are a result of infection with secondary bronchitis or pneumonia and tumor presence. Microscopic presence of carcinoma cells in sputum is common. It is uncommon, however, to see large portions of the tumor expectorated. Kelly et al have reviewed the literature and discussed expectoration of endobronchial tumors. This subject has been of interest to us over the years as first evidenced by our report published in 1974 in American Family Physician. We noted in this article a number of patients with unusual expectoration, including bullets, gauze sponge, wax packs, broncholiths, metal "Week" clips, shrapnel, and tumor casts of the bronchus. The patient mentioned in our article had a large poorly differentiated squamous cell carcinoma tumor cast of the bronchus expectorated postbronchoscopy. Since the time of that article in 1974, we have noted a number of patients with both primary and metastatic endobronchial lesions, who have expectorated bronchial casts or portions of the tumor, which on presentation to the laboratory for microscopic examination demonstrated the underlying etiology. We have found that most patients with significant hemoptysis, however, did not notice the presence of a tumor cast or mass; therefore, if such a specimen was present, it was not salvaged. We endorse further evaluation, endoscopic examinations, and radiographic review of any patient reporting expectoration of firm or hard tissue-like masses, even if the specimen has not been salvaged for gross or microscopic examination. A high index of suspicion will usually lead to definition of the underlying etiology even when radiographic findings appear normal.

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Environmental Tobacco Smoke Exposure and Adult Asthma

To the Editor:

Larsson and colleagues (September 2001) examined the relation between childhood environmental tobacco smoke (ETS) exposure and the prevalence of self-reported asthma in adulthood. As the authors point out, the effect of ETS exposure on childhood asthma induction is not in doubt. Based on > 40 epidemiologic studies, extensive data support a causal association between ETS exposure and induction of asthma in children. However, the relationship between ETS exposure and adult-onset asthma has received less attention.

The study of Larsson et al contributes to the literature linking ETS exposure with a greater risk of asthma. Unfortunately, the study does not clearly advance our understanding of how childhood ETS exposure affects the onset of asthma during adulthood. The study presents two alternate definitions of asthma, both of which measure lifetime prevalence of asthma. In other words, the prevalence of ever having asthma or having a physician diagnosis of asthma could reflect onset of asthma during childhood or adulthood. Without knowing the age of asthma onset, the observed association between childhood ETS exposure and adult asthma prevalence could be explained by the well-known relation between ETS exposure and childhood asthma.

Based on the available epidemiologic literature and strong biologic plausibility, ETS exposure is a likely cause of adult-onset asthma. To better define this relationship, future studies should evaluate incident, rather than prevalent, adult asthma cases.

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2 Nelson HS, Busse WW, Kervin E, et al. Fluticasone propionate/salmeterol combination provides more effective asthma control than low-dose inhaled corticosteroids plus montelukast. Given the fact that salmeterol itself is a bronchodilator, the observed difference in total supplemental albuterol use of −0.24 puffs (−1.90 vs. −1.66) is also surprisingly small. Finally, the statement that, to the authors' knowledge, "no other well-controlled studies comparing salmeterol and montelukast have been published," is difficult to understand, since two of the authors (A. E. and K. A. R.) are coauthors of a very similar study submitted 1.5 months before this one and published approximately 9 months earlier. In fact, when looking at the somewhat unclear design of the first study, there remains suspicion that part or all of this data was included in the second study.

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REFERENCES


Worry List

To the Editor:

The other day I asked Eileen when it was time to stop worrying about M. M is a pleasant, likeable guy in his forties, with a good sense of humor. He works construction for a local company. As far as I know, he works hard and pays his bills. In the office, we often joke around and swap stories. He tells me about his wild fishing trips on the Chesapeake. I tell him about the obnoxious parents I encounter at my son’s little league games.

When M comes in, it takes Eileen forever to get his BP. She enjoys his stories as much as I do.

We both like the one he told about spending 4 days on the bay with his fishing buddies. Didn’t catch a thing, he told us—not one tiny fish. He said one of the guys got so frustrated that he fished on a hand-held computer the last day of the trip.

“I learned a lot about myself on that trip, Doc. Blue skies, calm water, and good friends. Everything seemed perfect, and it really was, except for the fish. But hey, you can’t control everything.”

I’ve been M’s doctor for 5 years. On most visits I urge him to quit smoking. I don’t push hard, but I make sure he knows how I feel about it. He listens to me patiently. I see him maybe twice a year, which is a little more frequently than he sees his preacher, he tells me. Not that I preach, he quickly adds. He has been healthy, except for a period of depression 5 years ago during a messy divorce.

Last summer I discovered that M has a lung nodule. It showed up on a routine chest radiograph. It was his first chest radiograph ever. After a lot of back and forth, I had talked him into it (he smokes two packs a day).

“I don’t get it, Doc. I feel fine. There must be some mistake. Really, I’m okay.”

“I’m sure you feel fine, M. However, sometimes these things show up without symptoms. I think the next step is to do a CT scan to get a better look.”

“Doc, I’m fine. Don’t worry about me.”

“M, that’s hard for me to do, especially when you come to me for help. How about this—think it over, and call me tomorrow. This nodule could be many things, including cancer.”

“I’ve thought about it.”

“At least come back in 6 weeks for a repeat chest radiograph.”

“Sure.”

M did not show up for his 6-week appointment. I thought to myself: many patients live in a state of denial after receiving bad news. Maybe M is one of them. He has a history of depression—could he be depressed? Sometimes patients forget appointments, maybe he simply forgot. M does not own a car—maybe he missed the bus. Being a single dad is tough. Maybe he could not get a sitter for his kids. He once told me that his boss was a bastard. Maybe he couldn’t break free from work. Maybe he can’t afford the scan. Maybe he is too embarrassed to tell me that he cannot afford the scan. Maybe he’s simply scared. Maybe there are other reasons. Maybe the reason is none of my business.

I called him the next day and left a message on his machine to reschedule the appointment. Several weeks went by. No word from M. I asked Eileen to call him. She got him at work, and he promised to come in. He didn’t. I sent him a certified letter explaining the importance of finding out what was in his chest. I never heard back. For the next 6 months, Eileen and I tried to reschedule him. No show. No show. No show.

I keep a list of patients like M—patients with abnormal tests whom I worry may get lost to follow-up. Patients who miss scheduled tests. M had been on my worry list for over a year.

I know that seems like a long time to worry about a patient. But how long is too long? What would a medical ethicist say?

Several weeks ago, I decided to take M off the list. Don’t ask me why. Some combination of time, frustration, wisdom, prayer, other patients, and the final okay from Eileen. I don’t worry about him now. Really. Maybe he has cancer. Maybe he will die. Maybe he will sue me. No worry.

Your choices, M. Your life.

Months later, I saw M in the grocery store. He gave me a warm handshake that I gladly returned. We talked about fishing and baseball. We both had a good laugh. I did not ask him about his health. I think he appreciated that.

“You know, Doc, I’ve been thinking. Maybe I do need to come see you sometime.”

I smiled, shaking my head.

He smiled back.

“Maybe you do, M. Maybe you do.”

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Errata

In the March 2001 issue, the article, “Association of Airway Responsiveness With Asthma and Persistent Wheeze in a Chinese Population” (CHEST 2001; 119:691–700) by Xu et al, contained an error. On page 692, in the “Procedures” section, the last two sentences of the first paragraph should read: “Subject enrollment started in February 1995, after obtaining local China institutional review board approval. Brigham and Women’s Hospital institutional review board approval was received in September 1995.”

In the February 2002 issue, the article, “Inhibition of Human Neutrophil Elastase-Induced Acute Lung Injury in Hamsters by Recombinant Human Pre-elafin” (CHEST 2002; 121:582–588) by Tremblay et al, contained a typesetting error. In the first column of Table 1 (page 585), the entry “α1-Antitrypsin” should be followed by a double dagger (‡) instead of a single dagger (†).

Clarification

In the April 2002 issue, the editorial, “Balancing Self and Patient in the Physician-Patient Relationship” (CHEST 2002; 121:1019–1021) by Henry S. Perkins, contained a punctuation error. In the fifth paragraph, the second sentence should read: “While others may disagree, Miller, Shorr, and I suspect the physicians in this study failed in their fiduciary duties to patients.”