perform some household chores. In addition, the hair that had previously disappeared from her extremities (thought to be secondary to either the autoimmune disease or medication side effect) has regrown. Prior to oxygen therapy, her soft tissues in the extremities were painful with a boggy firmness, a fibromyalgia-like finding also thought to be part of the autoimmune syndrome. This symptom has gradually, but significantly, improved through a combination of body work (osteopathy and massage) and oxygen therapy. Prior to receiving supplemental oxygen, the same type of body work had been only minimally effective.

Researchers1–5 have reported exercise intolerance and pulmonary function in patients with mitochondrial dysfunction. Reports of aerobic training have documented increased oxidative capacity in adults. Chest 1995; 107:317–322

References

Irritable Bowel Syndrome Helped by Montelukast

To the Editor:

During my pulmonology practice, I encountered a patient who had asthma and nontropical sprue. I prescribed treatment with montelukast for this patient. To my surprise, the patient called me 1 week later to report that her sprue was completely better and that, 1 week after stopping her special gluten-free diet while remaining on montelukast, she was diarrhea free for the first time in 30 years! Her asthma also improved markedly. Taking my observation one step further, I initiated montelukast in another patient with sprue and with COPD without bronchospasm. To my amazement, her sprue also improved markedly, such that she was without diarrhea for the first time in 25 years and also on a normal diet.

Montelukast is an active leukotriene receptor antagonist that inhibits the cysteinyl leukotriene receptor.1 This may certainly explain the very positive effects of montelukast on patients who have sprue.2,3 It is also important to note that, in a recent study,4 20% of patients labeled with irritable bowel syndrome really had an incomplete case of sprue. I believe that many of these patients may also benefit from treatment with montelukast.

William H. Fee, MD
Chest Medicine Associates
Franklin, PA

Correspondence to: William H. Fee, MD, Chest Medicine Associates, 150 Prospect Ave, Franklin, PA 16323

REFERENCES

Pulmonary Involvement in Hepatitis B-Related Polyarteritis Nodoso

To the Editor:

We read with interest the report by Guo et al (July 2001)1 of a patient with hepatitis B-related polyarteritis nodosa (PAN) complicated by pulmonary hemorrhage. Pulmonary involvement, which is rare in patients with PAN, seems to be more frequent in patients with hepatitis B-related PAN, and endothelial cell damage by immune complex deposition could play a role.

Correspondence to: Carol Hutner Winograd, MD, 746 Esplanada Way, Stanford, CA 94305

REFERENCES

Pulmonary Involvement in Hepatitis B-Related Polyarteritis Nodoso

To the Editor:

We read with interest the report by Guo et al (July 2001)1 of a patient with hepatitis B-related polyarteritis nodosa (PAN) complicated by pulmonary hemorrhage. Pulmonary involvement, which is rare in patients with PAN, seems to be more frequent in patients with hepatitis B-related PAN, and endothelial cell damage by immune complex deposition could play a role.

Correspondence to: Carol Hutner Winograd, MD, 746 Esplanada Way, Stanford, CA 94305

REFERENCES