from a response of < 20%. Therefore, it is necessary in individuals with a PC_{20} of > 16 mg/mL to generate an actual interpolated PC_{20} or to establish the presence of a plateau. An extrapolation would not be accurate and would likely overestimate the response. In conclusion, PC_{20} should not be extrapolated when concentrations of > 16 mg/mL are administered.

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Lung Cancer Among Medical Professionals

To the Editor:

Mortality rates and causes of death among the members of medical staffs, especially medical doctors, have been reported; however, it is not clear whether lung cancer in such patients is at a more advanced stage at presentation than among members of other professions. In order to ascertain the characteristics of lung cancer in medical staffs, we reviewed the medical records of 1,021 lung cancer patients who had presented in our division between 1980 and 2001. There were 21 patients who were medical professionals (2.1%; 13 men; 7 doctors, 6 nurses, 3 dentists, 2 pharmacists, and 3 other technicians). The median age was 73 years (age range, 33 to 84 years). With regard to smoking, 71.4% of these 21 patients and 72.2% of 1,000 patients with other professions were smokers. There were no differences between the two groups. In the 21 patients, pathologic examination revealed a preponderance of adenocarcinoma (14 patients). A lower frequency of squamous cell carcinoma and small cell carcinoma (SCLC) among the members of the medical profession was striking in contrast to that found in the 1,000 patients with other professions (p = 0.0152 [χ^2 test]). Nineteen of the 21...
patients who were medical professionals (90.5%) had stage IIIB or IV disease, which was a more advanced-stage disease than that found in the other 1,000 patients (p = 0.0111). Three patients underwent surgical resection, and 10 patients received chemotherapy. Five patients received radiation, and three patients received palliative care.

Our study indicated that lung cancer among medical professionals had a propensity for advanced tumor stage at presentation and that smoking might have influenced the development of lung cancer. Health-care professionals may have a tendency to delay seeking medical advice. It is not clear why a lower frequency of squamous cell carcinoma and SCLC was observed among medical professionals. It might depend partly on the higher ratio of female patients among them. The high prevalence of smoking among health-care professionals is striking. Since smoking is an important factor in the occurrence of lung cancer, effective programs aimed at abstinence and the cessation of smoking are required. Moreover, practical systems for detecting early-stage lung cancer among medical professionals are needed. The behavior of health professionals toward seeking medical attention is another issue that should be raised.

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Bronchial Asthma in the Very Elderly

To the Editor:

Bronchial asthma (BA) is not rare in the elderly and causes significant morbidity and mortality.1,2 BA beginning after the age of 50 years is more severe and less reversible than asthma in children.3 We reviewed the clinical features and management of six patients ≥ 80 years old with BA diagnosed in our hospital over the past 10 years (mean age, 87 years; range, 80 to 97 years). Four patients had a history of cardiovascular disease, and one patient had a history of cerebrovascular disease. The bronchodilator inhalation test at ≥ 80 years of age resulted in a 16.0 to 43.2% (mean, 26.9%) increase in FEV1. Five patients received oral β2-agonists, and four patients received oral theophylline. At the time of exacerbation of BA in one patient, theophylline was administered IV and the serum theophylline level was temporarily elevated to the toxic range. This toxicity might be due to the simultaneous administration of oral quinolone antibiotics. Five patients received inhaled steroids; however, in one patient steroid inhaler was not prescribed because of poor adherence to aerosol because of its odor.

We showed that in patients ≥ 80 years old, BA continues to have significant reversibility. The treatment of such patients is further complicated by concomitant disease and pharmacologic interactions, and thus elderly people may not receive optimal treatment for BA.2,3 In the presence of coronary artery diseases, hypoxemia due to asthma and cardiac side effects from β2-agonists and theophylline may amplify the morbidity in elderly patients.1,4 Side effects from excessive β2-agonists and theophylline should be avoided by careful monitoring of symptoms and drug levels in patients at risk of heart disease.5 Additionally, inhaler technique can be a particular problem in elderly patients with BA; however, inhaled steroid is safe and effective, and is indicated especially elderly asthmatics without fear of severe complications. The choice of an appropriate treatment for elderly patients with BA needs careful consideration of the severity of the disease and coexisting diseases, and the level of treatment required.

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Erratum

In the April 2002 issue, the article, “Prolonged Endurance Challenge at Moderate Altitude: Effect on Serum Eosinophil Cationic Protein, Eosinophil Dynamics, and Lung Function” (CHEST 2002, 121:1111–1116) by Domej et al contained two errors. On page 1112 (Table 1) and page 1113 (“Results” section), the time of descent (mean ± SD) should be 34 ± 8 min (range, 24–50). In Table 2, the reference range for the eosinophil count should be 150–600 cells/μL.