nutritional factors associated with increased body weight might be protective against the development of COPD. 8

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REFERENCES

Dry Talc Pleurodesis Via Chest Tube

To the Editor:

Parulekar et al [July 2001] 1 report an interesting retrospective review of malignant pleural effusions drained with small-bore catheters or large-bore chest tubes. Most of their patients received tetracycline as the sclerosant and not surprisingly showed only a 51 to 53% long-term success rate. Although the success rate is disappointing, it is noteworthy that smaller-bore catheters were as effective as large tubes.

Of perhaps greater importance is their allusion to the use of dry talc installation was not retrieved.

21 days). Information regarding days of drainage relative to talc installation? We measured the duration that the tube was in place before and after talc installation. During the period of interest, all patients who underwent talc installation by large tube also underwent insulation. Eleven patients were in this group.

We read with interest the article by Bashar et al (November 2001). 2 The authors have used “odds ratio” interchangeably with “relative risk” while discussing multidrug-resistant tuberculosis (MDR-TB) among diabetes patients, which is not correct.

Among diabetes patients, 13 of the 18 MDR-TB patients were enrolled in directly observed therapy (DOT), compared to only 4 of 10 patients in the control group. Therefore, the enrollment in DOT itself becomes an important confounding factor for studying the incidence of MDR-TB among diabetic patients receiving DOT. Without controlling for this confounding factor, it is not

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REFERENCE

To the Editor:

In reply to your questions:

1. Of the 27 patients receiving talc, how many received it by insufflation via large tube? During the period of interest, all patients who underwent talc installation by large tube also underwent insulation. Eleven patients were in this group.

2. What were the 30-day and long-term successes of these patients? Of the 11 patients, 3 patients had recurrence of pleural effusions within a median follow-up period of 5 weeks (range, 3 to 15 weeks). Eight patients had no recurrence at a median of 8 weeks of follow-up (range, 1 to 94 weeks). We saw no difference in the long-term success rates of the large- vs small-bore groups treated with talc (W. Parulekar, MD; unpublished data; June 2002). Seven patients were followed up for at least 30 days; three patients had a recurrence. One of four patients followed up for at least 100 days had a recurrence.

3. Were patients insufflated with milliliters or grams of talc? This information was not specifically recorded at the time of data retrieval. However, the patients were treated at a tertiary hospital with an active thoracic surgery department; it is a fair assumption that the dose delivered was in keeping with current practice.

4. Is there a record of the days of drainage before and after talc installation? We measured the duration that the tube remained in place. For this small group of patients, the median duration of tube placement was 7 days (range, 3 to 21 days). Information regarding days of drainage relative to talc installation was not retrieved.

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Does Diabetes Predispose to the Development of Multidrug-Resistant Tuberculosis?

To the Editor:

We read with interest the article by Bashar et al (November 2001). 2 The authors have used “odds ratio” interchangeably with “relative risk” while discussing multidrug-resistant tuberculosis (MDR-TB) among diabetes patients, which is not correct.

Among diabetes patients, 13 of the 18 MDR-TB patients were enrolled in directly observed therapy (DOT), compared to only 4 of 10 patients in the control group. Therefore, the enrollment in DOT itself becomes an important confounding factor for studying the incidence of MDR-TB among diabetic patients receiving DOT. Without controlling for this confounding factor, it is not

Correspondence to: Wendy Parulekar, MD, Physician Coordinator, National Cancer Institute of Canada, Queens University, 82 Barrie St, Kingston, ON K7L 3N6; e-mail: wparulekar@ctg.queensu.ca
correct to report that patients with tuberculosis (TB), who are both diabetic and receiving DOT, will have 49-fold greater chance of having MDR-TB. The positive aspect of DOT intervention, that all 13 MDR-TB patients with diabetes receiving DOT were successfully treated, needs to be highlighted instead.

Reasons for higher rate of MDR-TB among diabetic patients (36%) compared to 10% among control group are difficult to explain. The authors have not mentioned any plausible scientific explanation with published reference for this observation. Possible malabsorption of anti-TB drugs among diabetic patients, as mentioned by the authors, has not been documented so far. During the study period, from 1987 to 1997, New York City was going through rapid changes in the incidence of HIV infection. Also, the implementation of DOT as a standard therapy in 1992 led to a drastic fall in the incidence of MDR-TB in New York City. These factors have not been controlled properly and might have influenced the results of the study. It is surprising that the number of MDR-TB cases in the study remained the same during the 11-year period from 1987 to 1997. This study was also limited by its small number of subjects and by retrospective data collection.

At Sahary Chest Hospital, Riyadh, Saudi Arabia, a retrospective review (unpublished data) revealed that among sputum smear-positive pulmonary TB patients, no MDR-TB case was detected among 126 diabetic patients compared to 10 MDR-TB cases among 389 nondiabetic control patients. We feel that we should wait for more studies before we believe that diabetes is a significantly high risk factor for the development of MDR-TB.

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We agree with the assertion that the odds ratio is not interchangeable with the relative risk. Obviously, relative risk could not be calculated directly, as our study was of a case-control design. The odds ratio estimates the relative risk, with a slight systematic bias (arising from the difference between odds and risk). We therefore chose to use the term relative risk to denote its (odds ratio) estimator. To be perfectly correct, we could have used the term odds ratio only. We regret any confusion that our use of terms might have caused.

With regard to the observation of Drs. Singla and Khan of no MDR-TB among a sample of patients in Riyadh, we are not surprised by the disparate findings in different samples. Further and more conclusive investigations should be done to examine the possible link between diabetes and drug-resistant tuberculosis in different locales. As widespread as tuberculosis is, its occurrence remains an intensely local phenomenon.

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Megestrol Complications

To the Editor:

I am writing following the publication of a recent article in CHEST, which reported that megestrol acetate safely increases appetite and body weight among underweight COPD patients.

In that report, the authors did not report any complication from megestrol acetate therapy, and this result is very different from our experience in a local nursing home, reported in the Journal of the American Medical Directors Association. In our study, the incidence of deep vein thrombosis among 19 patients treated with megestrol acetate was 87.952 cases per 100,000 patient-years. This rate is appreciably higher than reported rates among older adults (300 to 800 cases per 100,000 patient-years).

Concluding that megestrol acetate treatment for appetite stimulation is safe based upon a randomized study of 145 patients treated for only 8 weeks seems premature. Until larger, randomized, prospective, controlled trials of megestrol acetate treatment vs no other treatment for patients at-risk nutritionally are conducted, clinicians should proceed cautiously in using this drug. If megestrol acetate is prescribed, examination for deep vein thrombosis should be done regularly, and a high index of suspicion for this complication should be maintained.

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