To the Editor:

We thank Professors Molinard and Moore for their interest in our article. They have some concerns regarding study design. As they are not clinicians, perhaps they are unaware that studies in severe asthma are very difficult to conduct. These patients are a major management problem and are usually excluded from conventional drug therapy trials. Any improvement in treatment would be a valuable addition to management in this difficult group of patients. Our study aimed to determine whether these patients would be better treated with either salmeterol or formoterol, and we described in the article the theoretical reasons why differences might be expected. We found that both drugs significantly increased mean morning peak flow by approximately 15 L/min above placebo. Consequently, we should have detected a similar difference in peak flow between the two drugs. However, due to the high number of patient withdrawals, the power of our study was less than originally predicted. In regard to choice of drug doses, we wished to compare the drugs at doses used in current clinical practice. Therefore, doses were chosen on this basis rather than those most likely to give a positive result. A double-blind, double-placebo design would have been preferable to the use of just one placebo. However, a matching salmeterol placebo was not available from the manufacturers. We felt it was preferable to include a single placebo rather than no placebo at all. Finally, our study has shown that, albeit not differing in efficacy, both drugs improve lung function in severe asthma and should prove useful in treatment of this difficult patient group.

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Endobronchial Actinomycosis and Foreign Body

To the Editor:

We read with interest the article by Chouabe et al (June 2002) on endobronchial actinomycosis associated with a foreign body. We would like to share our experience. A 75-year-old man presented with productive cough and fever. The chest radiograph revealed atelectasis in the right lower lobe. A thoracic CT scan showed calcified material in the right lower bronchus. Fiberoptic bronchoscopy revealed a granulomatous reaction in the right lower bronchus suggestive of a tumor almost obstructing the bronchial lumen, but the foreign body was not identified at the initial examination. Testing of an endobronchial biopsy specimen showed marked chronic inflammatory cell infiltration and proliferation of granulation tissue. The granulation tissue was tested by Gomori methenamine-silver stain and was positive for Actinomyces. The patient was treated with penicillin G for 2 weeks. On follow-up bronchoscopy, the granulomatous lesion in the right lower bronchus had disappeared. At the end of this procedure, the patient coughed out a botanical seed, which was confirmed by microscopic examination. The calcified material in the right lower bronchus disappeared in the thoracic CT scan. For the adverse effect of penicillin G, the patient received erythromycin for 6 months. The condition of our patient was very similar to that of the patient in the report by Chouabe et al, and we can fully share their observations. Antibiotic therapy and also extraction of the development of sleep apnea educational programs by the sleep community to date no sleep apnea educational programs have been developed, instituted, and tested in a prospective, randomized manner among health-care providers. However, any sleep apnea educational intervention will not only need to increase physician recognition and treatment of sleep apnea, but will also need to demonstrate an improvement in patient outcomes. Thus, as Drs. Littner and Alessi suggest in their editorial, it is these patient outcomes that will further persuade health-care providers to identify and treat even more patients with sleep apnea.

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References

foreign body are important for the treatment of patients with bronchial actinomycosis that is associated with the presence of a foreign body.

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