randomized to therapy with vancomycin died than did patients randomized to therapy with linezolid. Therefore, we think that the conclusion that linezolid “is associated” with lower mortality rates and greater clinical success rates than vancomycin in patients with MRSA pneumonia is valid.

We, as the nonemployee authors of these manuscripts, and many other clinicians who have been presented these data have raised the same concerns about subgroup analysis as have Powers and colleagues. Because of these concerns, Pharmacia (now Pfizer Inc) has sponsored a direct comparison of vancomycin and linezolid specifically in patients with MRSA ventilator-associated pneumonia. Until this and possibly other studies are completed, we agree with Powers and colleagues that clinicians should exercise care in drawing conclusions based on subgroup analysis. We differ with them, however, in that we think that the analysis of the MRSA subgroup that we published is more pertinent to the clinical care of patients with MRSA pneumonia than the “clinically evaluable” and “microbiologically evaluable” subgroup analyses of the entire cohort favored by Powers and colleagues.

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Nasal Airflow in Sleep-Disordered Breathing

To the Editor:

The excellent review by Rappai et al (December 2003)1 of the nose and sleep-disordered breathing was timely and needed. Unfortunately, I think the authors did not clearly state the major reason why this subject remains unclear and controversial. Plainly stated, reliable, simple, reproducible clinical measurements of nasal airflow and nasal anatomy must be available before the role of nasal obstruction in sleep-disordered breathing can be defined.

For the practicing clinician, the tests covered in the review, including peak nasal flow, rhinomanometry, and acoustic rhinomanometry, are generally not available, and their correlation with anatomic or dynamic obstruction has not been uniformly accepted. There are two tests that did not receive attention in the review and should be considered when discussing nasal airway obstruction.

The use of radiographic procedures, which was not chosen to

Figure 1. This is an example of a symptomatic patient with fixed nasal inspiratory airflow obstruction on FINFVC. The forced inspiratory flow is 1.2 L/s. On the CT scan, the nasal passages demonstrate enlarged turbinates with narrowed nasal lumen. Reprinted with permission from Hooper.2

Communications to the Editor
be reviewed by the authors, has received little attention in the literature as a technique to measure airway patency. A standard screening sinus CT scan, performed in the coronal plane, gives an excellent view of the nasal passages and gives a visual estimate of the patency of the nasal airway. The cross-sectional area of each nasal passage can be measured with most scanning equipment and could be used in scientific investigations. More importantly, a sinus CT scan is a widely available tool that can be readily obtained.

A visual and numerical measurement of nasal flow, the forced inspiratory nasal flow volume curve (FINFVC), should be included in the list of tools for the evaluation of nasal airflow obstruction. I have previously reported on the technique and its use to evaluate nasal airflow. It utilizes the measurement of the flow-volume relationship applied to a forced inspiratory maneuver that is measured at the nose. When used with a sinus CT scan, the two techniques more clearly define the processes involved in nasal airflow obstruction than the techniques reviewed by Rappai et al1 (Fig 1).

Until tools such as sinus CT scans and the FINFVC are employed to quantify nasal airflow obstruction anatomically and physiologically, the role of nasal airflow obstruction in sleep-disordered breathing will be uncertain. At present, the FINFVC and coronal sinus CT scans are the best tools available.

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To the Editor:

We appreciate Dr. Hooper’s kind comments concerning our article (December 2003). In his letter, he also ardently proposes that the coronal CT scan and the “forced inspiratory nasal flow-volume curve,” which he has described elsewhere, are the “best tests available” to assess nasal airflow structurally and physiologically.

We agree that CT scanning and MRI are among the appropriate methods with which to evaluate nasal airway structure. We disagree that CT scanning or MRI provides a visual estimate of airway patency, which is necessarily subject to dynamic fluctuations, such as the nasal cycle, alar collapse on forceful inspiration, or the influences of medications or hormones. We reviewed five such modalities for dynamic assessment in our article. Additionally, authors in a well-regarded textbook of otolaryngology specifically recommend rhinoscopy (not CT scanning or MRI) for the initial structural evaluation of nasal airway obstruction.

The forced inspiratory nasal flow-volume curve is an interesting concept that combines nasal inspiratory peak flow with the assessment of nasal vital capacity. As with other measurements of nasal peak flow, this potentially may be useful in the detection of large changes in nasal patency in individual subjects. It also may be among the most economical methods of evaluating nasal patency dynamically. However, it is limited by subjective variables of patient effort, and by observer interpretation of the proper technique and effort, as are other measurements of peak flow, whether nasal (as in nasal obstruction) or oral (as in lower airway obstruction). Nonetheless, this concept may appeal to some clinicians. Rhinomanometry is the best studied method for measuring nasal flow and resistance, and remains the standard for comparison.

We do not endorse any specific diagnostic modalities. We observe that choice necessarily depends on cost, convenience, individual preference, and an informed knowledge of the strengths and weaknesses of each modality. Due to the dynamic nature of airway obstruction, however, functional assessment is strongly recommended.

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References


Treatment of a Primary Pulmonary Angiosarcoma

To the Editor:

We read with interest the article by Kojima and colleagues (December 2003) concerning the treatment of a primary pulmonary angiosarcoma (AS). They used simultaneously IV recombinant interleukin-2 (rIL-2) and external radiotherapy (RX) for treating this nonmetastatic inoperable AS. Kojima and associates wrote in their article that “this combination therapy may be a promising strategy to prolong the survival of patients with primary pulmonary angiosarcoma.” Although they obtained a surprising and sustained good response (more than a year) in this case, we would like to make a few comments.

rIL-2 has often been tried to treat different types of cancers. Tumor responses were observed mainly in patients with melanoma and renal cell carcinoma. Kojima et al mentioned the study of Masuzawa et al and wrote that the “systemic administration of high doses of rIL-2 was also highly effective and