the pool and number of critical care fellowship positions and trained intensivists. Ultimately, it is in the best interests of our patients.

Carey D. Chisholm, MD
Donald M. Yealy, MD
on behalf of the Board of Directors
Society for Academic Emergency Medicine
Lansing, MI

Reference

Treatment Outcome in Mycobacterium avium Pulmonary Disease

A Correction and Comment

Huey Long ("Kingfish"), the famously corrupt, demagogic, depression-era governor of Louisiana, was interviewed by a high school senior, whose last question was, “Tell me, governor, is there a place for honesty in politics?” Long replied, reassuringly, in the affirmative, but as the student left the room, he winked at his surrounding cronies and commented, “In politics, boys, we use anything we can get!” We applied the same expediency rule his surrounding cronies and commented, “In politics, boys, we use anything we can get!” We applied the same expediency rule in our treatment of pulmonary disease due to Mycobacterium avium.

Due to a misinterpretation of our data,1 the authors of a recent review of the treatment of M avium pulmonary disease2 conveyed a misleadingly pessimistic view. They assumed (Stephen Field, MD, FCCP; personal communication; August 29, 2004) that individuals in whom surgery was an adjunct to medical therapy and those who had responded to drug treatment, as indicated by sputum conversion and radiographic improvement, but whose information had not been completed when we collated our data, were treatment failures. They excluded from consideration two patients whose primary treatment was surgery. Consequently, they considered that only 6 of 14 patients (43%) were treated successfully.

Sixteen of our patients were judged to be suitable for aggressive management, and 2 patients underwent surgery as the primary treatment. In Table 1 of the article by Reich and Johnson,1 case 17 was a 3-year-old child with unexplained right hilar adenopathy and middle lobe opacification. The diagnosis was established based on histology and the results of a culture of epithelioid granulomas that were indistinguishable from positive Kvein test results.

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REFERENCES
4 Reich JM. Primary pulmonary disease due to Mycobacterium avium-complex [letter]. Chest 1993; 104:651
but can tolerate lung resection as a life-saving procedure. We measure for the minority of patients who fail medical therapy. Our opinion is that surgery is a desperate and last-stage patients is too widespread for surgery to be a consideration. We completed, death, and the need for surgery as failures of relapse during or after treatment was with medication therapy, relapse during or after treatment was medication trials did not include surgery as a routine part of different investigators, we had to define success and apply that previous authors had used various definitions for treatment three patients described as "treatment not completed." The underwent surgery prior to medication therapy, so we limited the our review was to focus interest on Mycobacterium avium lung disease, and it appears that we have been successful. Surgery was part of the treatment plan for 6 of the 16 patients with M. avium lung disease reported by Reich and Johnson. Although there are no properly designed trials, surgery has been reported to convert sputum to negative in patients with localized lung disease who previously failed drug therapy. Dr. Reich described surgery as an adjunct to medication therapy, but inadequate pulmonary reserve precludes surgery in many patients with M. avium lung disease; in those who undergo surgery, postoperative morbidity including hemorrhage, empyema, and bronchopleural fistula are common complications. Moreover, lung involvement in many patients is too widespread for surgery to be a consideration. Our opinion is that surgery is a desperate and last-stage measure for the minority of patients who fail medical therapy but can tolerate lung resection as a life-saving procedure. We do not feel that surgery should be part of the routine management of these patients.

In the treatment section of our review, we discussed that previous authors had used various definitions for treatment success. To allow comparison between the results of the different investigators, we had to define success and apply that definition in a similar fashion to the various reports. Most medication trials did not include surgery as a routine part of their treatment regimen. We defined the inability to complete medication therapy, failure of sputum to convert to negative with medication therapy, relapse during or after treatment was completed, death, and the need for surgery as failures of medication therapy.

We were not sure how to categorize the two patients who underwent surgery prior to medication therapy, so we limited the analysis to the other 14 individuals reported by Reich and Johnson. Three of 14 patients were reported as "treatment not completed," and 4 patients required surgery despite drug therapy. Dr. Reich's present communication now clarifies the status of the three patients described as "treatment not completed." The other seven patients converted to negative, but one patient relapsed. Consistent with our interpretation of the other treatment reports, we categorized the 6 of Dr. Reich's 14 patients who were able to complete drug therapy, whose sputum converted to negative, and did not relapse, as drug treatment successes. Changing the status of these three patients to treatment successes in our Table 4, which includes the patients treated with regimens that included ethambutol and/or rifampin, changes the overall success rate from 37.7% to 38.1%.

To the Editor:

We would like to thank Dr. Reich for his thoughtful comments and for providing additional information about the patients described in his previously published article. The major aim of our review was to focus interest on Mycobacterium avium lung disease, and it appears that we have been successful.

Surgery was part of the treatment plan for 6 of the 16 patients with M. avium lung disease reported by Reich and Johnson. Although there are no properly designed trials, surgery has been reported to convert sputum to negative in patients with localized lung disease who previously failed drug therapy. Dr. Reich described surgery as an adjunct to medication therapy, but inadequate pulmonary reserve precludes surgery in many patients with M. avium lung disease; in those who undergo surgery, postoperative morbidity including hemorrhage, empyema, and bronchopleural fistula are common complications. Moreover, lung involvement in many patients is too widespread for surgery to be a consideration. Our opinion is that surgery is a desperate and last-stage measure for the minority of patients who fail medical therapy but can tolerate lung resection as a life-saving procedure. We do not feel that surgery should be part of the routine management of these patients.

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Chylothorax in Hematologic Malignancies

To the Editor:

I read with interest the excellent article by Alexandrakis et al.1 in which current knowledge regarding the hematologic entities associated with pleural disease is extensively reviewed. The authors mention that the pleural fluid may be chylos (chylothorax) in some disorders such as non-Hodgkin lymphoma, Castleman disease, and as a late complication of thoracic irradiation. However, a reference to chylothorax in other appointed disorders such as chronic lymphocytic leukemia (CLL) and Waldenström macroglobulinemia is absent. I would like to make some comments about these specific subjects.

Chylothorax, a milky white fluid from a pleural space, usually results from disruption of the thoracic duct or its tributaries. This fluid contains a high level of triglyceride (> 110 mg/dL), an essential feature for its diagnosis. The presence of chylomicrons is also indicative of chylothorax.2 More than 50% of chylothorax is due to malignancy, and lymphoma accounts for 75%, followed by lung carcinoma.2,3

CLL of the B-cell type is the most common leukemia affecting adults, and may infiltrate any organ. Parenchymal infiltrates and pleural effusion are frequent manifestations in the lung, with chylothorax being less usual (Table 1). The rarity of chylothorax in CLL has been attributed to the very uncommon mediastinal lymphadenopathy although the biological features of some tumor may contribute to their appearance.3,4

Waldenström macroglobulinemia is a rare lymphoproliferative disorder (up to 2% of hematologic malignancies) affecting mostly elderly people, and the lung could be involved in up to 5%.4,5 A chylos effusion is an infrequent and usually late complication. Few cases of initial or evolutive chylothorax associated with Waldenström disease appears in MEDLINE (Table 1).

Management of chylothorax includes therapy of the underlying disease associated with other conservative measures, such as drainage of pleural effusion, maintenance of nutritional condition, and chemical pleurodesis. Surgical therapy is proposed when conservative treatments have failed.3 Since the rarity of these conditions demand a higher index of suspicion, their inclusion in reviews could help to direct diagnostic work.

Enrique Antón, MD, PhD
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Table 1—Reported Cases of Chylothorax Associated With CLL and Waldenström Macroglobulinemia (MEDLINE)

<table>
<thead>
<tr>
<th>Chylothorax and CLL</th>
<th>Waldenström Macroglobulinemia</th>
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<tbody>
<tr>
<td>Ampil et al/1993</td>
<td>Rizzo and Campagnoli/1984</td>
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<td>Aranda and Aguinaco/2001</td>
<td>Antón/2001</td>
</tr>
<tr>
<td>Doerr et al/2002</td>
<td>Rice and Milstone/2004</td>
</tr>
</tbody>
</table>

References
2 Maskell NA, Butland RJA. BTS guidelines for the investigation of a unilateral pleural effusion in adults. Thorax 2003; 58(suppl II):8–17

To the Editor:

We thank Dr. Antón for his interest in our review. He is right that pleural disease in patients with hematologic malignancies should also include chylothorax in patients with chronic lymphocytic leukemia and Waldenström macroglobulinemia. However, one additional case of chylothorax in a patient with Waldenström macroglobulinemia1 also should be included in Table 1 of the letter from Dr. Antón. A case of primary macroglobulinemia associated with pseudochylothorax in a Japanese patient also has been reported.2 Pseudochylothorax is a chyliform fluid in the pleural space.3 Chylomicrons are absent, and this effusion has nothing to do with lymphatic vessels or chyle. Most pseudochylothoraces have cholesterol levels of > 250 mg/dL and triglyceride levels of < 110 mg/dL. The addition of 1 to 2 mL ethyl ether

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