positive regard they have for the hospital. It is difficult to imagine a group more predisposed to agree with the clinicians in their judgments about what constitutes inappropriate care.

Second, at the same time that the Texas law grants this sweeping authority to ethics committees, it precludes any possibility of an appeal to the judicial system. Judges are authorized only to grant extensions of the decision (and even then only if necessary to find an alternative care provider); judges are not authorized to question or to overturn the decision itself. In our view, the Texas law appears to be at odds with one of our most cherished legal traditions by denying access to due process to those with unpopular values.

Finally, while agreeing that clinicians have positive obligations to promote good stewardship of scarce health-care resources, the data cited in our article show that only a surprisingly small amount of money could be saved by eliminating treatments judged to be medically futile. This counterintuitive claim is possibly explained by the fact that the vast majority of disputes over life-sustaining treatments are resolved through negotiation, as they should be. But, regardless of the reason, the fact remains that legislation like that in Texas cannot be justified as an effective approach to cost control. In sum, while the claims of Pope and Waldman may be relevant in general, they do not apply to medical futility and the Texas legislation.

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The authors have reported to the ACCP that no significant conflicts of interest exist with any companies/organizations whose products or services may be discussed in this article.

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DOI: 10.1378/chest.08-1613

REFERENCE


The Lady Windermere Syndrome

Is There a Racial As Well as a Gender Bias?

To the Editor:

Jeffrey Glassroth wrote a fine review of nontuberculous mycobacterial pulmonary disease in CHEST (January 2008). Judging from a number of reports, as summarized in the 2007 American Thoracic Society/Infectious Diseases Society of America Nontuberculous Mycobacterial Disease Statement, the Lady Windermere syndrome has been said to more common in white women than in women of African or African-American background. It may be more common in Asian women as well. However, since these observations have come from case series, the apparent racial bias may not be genuine. The strongest data pertaining to this topic this writer have discovered are in a doctoral thesis published in 2004.

In 2000, according to the US Census Bureau, Harris County, TX, had a population of approximately 3,400,000, and a rough white-to-black ratio of about 3:1. The actual figures on race were listed as follows: 58.7% white; 18.5% black or African American; 0.4% American Indian and Alaska Native; 5.1% Asian; 0.1% Native Hawaiian and other Pacific Islander; 14.2% some other race; and 3.0% two or more races. It was noted that some persons declared two races, making the total exceed 100% by a small percentage.

A study was done of HIV-negative women aged ≥ 50 years in Harris County between January 1998 and December 2000 who had at least one positive Mycobacterium avium complex (MAC) culture from a pulmonary source, as obtained from the records of hospitals and clinics in the county. Only women with incident cultures positive for MAC for the 3-year collection period were included. Cultures were identified as positive for MAC by growth on solid media or broth methods (BACTEC; Becton Dickinson; Sparks; MD), and results confirmed using a DNA probe technique. A laboratory and population-based surveillance program for Mycobacterium tuberculosis and MAC had been in place since 1997 in Harris County through cooperative efforts between the Baylor College of Medicine, the University of Texas Health Science Center, about 40 Houston-area hospitals, and the Centers for Disease Control and Prevention in Atlanta, GA. This was done as part of the Houston Tuberculosis Initiative, which tracks tuberculosis in the Houston metropolitan area. A comparison population was selected from tuberculosis suspects found throughout Harris County. A hybrid study design using both cross-sectional and case-control methodologies was used. There were 136 subjects with positive MAC culture findings identified and included in the study, and 136 control subjects who had been tuberculosis suspects. The self-declared race of the MAC culture-positive women was “white” in 125, “black” or “African American” in 7, and “Hispanic” in 11. After various risk factors were controlled for, subjects with positive MAC cultures were more likely to be white (odds ratio, 4.6; 95% confidence interval, 2.3 to 9.2). In addition, they were more likely to have bronchiectasis, scoliosis, and pleural disease and lung cavitation on radiography than the control subjects. Cavitation was especially interesting because that traditionally had not been part of the Lady Windermere syndrome. Whether this represented a true genetic difference in susceptibility, and/or differing environmental exposures, or some combination remains unknown at the present time, although it would seem likely that genetics might have had a considerable role.

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The author has no conflict of interest to disclose.

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DOI: 10.1378/chest.08-1428

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To the Editor:

We read with great interest the article in CHEST (July 2002) by Masakazu et al.1 who observed a haplotype loss of class I human leukocyte antigens (HLAs) in several newly established lung cancer cell lines and identified it as a mechanism of tumor escape from the immunosurveillance system of the host. However, as for the HLA genes of lung cancer cell lines passing for many generations, such as the A549 and Calu-6 cell lines, there have been few reports, and the results have been inconclusive. Rimmelzwaan et al.2 reported that the genetic types of HLA-AB in A549 cell line become HLA-A30/HLA-A25 and HLA-B44/HLA-B18, while Hanagiri et al.3 reported that the presentation of HLA-A in the A549 cell line becomes HLA-A30/HLA-A26. We present our results on genetic type HLA-ABDR in the A549 cell line (CCL-185 in the American Type Culture Collection) and in the Calu-6 cell line (HTB-56 in the American Type Culture Collection) via the polymerase chain reaction-sequence-specific priming method4 as follows: (1) HLA-A30/–, HLA-B44/–, HLA-DR7/HLA-DR53 (A549 cell line); and (2) HLA-A01/–, HLA-B08/–, HLA-DR17/DR52 (Calu-6 cell line).

The reason for the different results in the two previously published studies2-3 on the A549 cell line may be the 97.6% homology between HLA-A25 and HLA-A26. However, our study results indicated that there is a haplotype loss of HLA-AB in the A549 cell line. Also, there is a haplotype loss in the Calu-6 cell line. Hence, our results strongly support the fact that there is a haplotype loss of HLA-AB in the A549 cell line.

The HLA-I gene is present in many kinds of tumor cells, such as lung cancer cells. Intriguingly, in spite of continuing for many generations, the two cell lines wholly retain the HLA-DR genes. This result is different from a reported study6 in which there was also found to be a haplotype loss of HLA class II genes in all of the three newly established lung cancer cell lines. The correlative mechanisms of "haplotype loss" and "whole retention" of HLA class I/II genes are novel, and it is necessary to determine their cause as the next step in research.

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DOI: 10.1378/chest.08-1058

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Obstructive Sleep Apnea and Perioperative Complications

To the Editor:

We thank Hwang et al.7 for their work that correlates sleep-disordered breathing with postoperative complications; however, we would like to raise a few issues in this respect:

1. The authors have opined that screening modalities of obstructive sleep apnea (OSA) have largely been based on expert opinion with lack of clinical evidence. Such is clearly not the case: questionnaires like Berlin,2 STOP (Snoring, Tiredness during daytime, Observed apnea, high blood Pressure), and STOP-Bang (Body mass index, Age, Neck size, Gender)8 are available and have been clinically validated. The STOP and STOP-Bang questionnaires are particularly concise, easy to administer, and particularly validated in surgical patients and show high sensitivity for moderate-to-severe OSA.3 Clearly, use of such validated simple methods would be less cumbersome than the use of nocturnal oximetry as used here, and these could be used for future studies.

2. It has been established that OSA4 is associated with increased perioperative morbidities more so with general anesthesia and perioperative use of opioids. A sizable proportion of patients (62 of 172) underwent surgeries (gynecologic, urologic, and orthopedic) which, depending on site and type of surgery, could either have been done under regional or general anesthesia. The authors have not clarified the type of anesthetic administered in these; nor have they clarified the protocol of general anesthesia, whether it was standardized for all patients, the analgesic modality followed in the various surgeries. These missing factors have a bearing on the perioperative outcome. In the absence of such information, it becomes difficult to interpret the contextuality of the data.

3. The inclusion of complications (GI bleed and intraperitoneal bleed) completely unrelated to the topic under inves-