Correspondence

Asthma Deaths

TO THE EDITOR: The concern expressed by Dr Sharma on the rising incidence of death from asthma is a real issue.[1] In his article in the November 1989 issue, the author also advocated using aerosolized corticosteroids (AC) before a trial of cromolyn sodium is attempted. I find the reasoning behind this quite puzzling. Granted that ACs are relatively safe and usually more effective than cromolyn, but they are not entirely free of side effects. Whereas ACs are not infrequently associated with oropharyngeal candidiasis and myopathy of the laryngeal muscles, cromolyn is practically free of side effects.

Even more disturbing, the author apparently overlooked the role of antiallergy management in his recommendations, even though he alluded to the fact that those who are allergic "are at an increased risk for acute severe attacks of asthma." One would reason that if allergens do play such an important role in the severe attacks, some efforts should be made to identify these allergens. As I see it, the major schism between many pulmonologists and allergists is that the former mostly neglect the roles of avoiding allergens (especially pets, house dust mites, etc) and of immunotherapy in antiasthma treatment. The rising rate of asthma deaths in the face of ever more potent antiasthma drugs would seem to highlight the fact that this battle is unlikely to be won by pharmaceutical agents alone.

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Thymic Carcinoid and Multiple Endocrine Neoplasia

TO THE EDITOR: I read with interest Venkatesh and Samaan's description of the University of Texas MD Anderson experience with six cases of thymic carcinoid tumor.[1] I am treating a similar case, and the patient is also from Texas. Because such cases are unusual and can present difficult and prolonged management problems, it may be useful to add my experience to the literature.

Report of a Case

A previously healthy 35-year-old man had a parathyroid adenoma resected in 1983. Chest pain subsequently developed, and a 6- by 5- by 4-cm superior mediastinal thymic carcinoid was removed during a left parasternotomy in March 1985. His serum calcium level was 2.99 mmol per liter (12.0 mg per dl), serum phosphorus 0.61 mmol per liter (1.9 mg per dl), the C-terminal parathyroid hormone (PTH) was 268.5 pmol per liter (normal 45.3 to 195.9), and the N-terminal PTH was 168.5 pmol per liter (24.2 to 66.3) at American BioScience Laboratories; a blood serotonin level was 130.4 nmol per liter (normal 283.5 to 1,134). Postoperative calcium levels remained elevated, and he received irradiation to the mediastinum. Four months later, right supraclavicular lymphadenopathy developed and was excised. Both the mediastinal tumor and the supraclavicular mass were interpreted as carcinoid, composed of small, round cells with brightly eosinophilic cytoplasm and small, round nuclei. Immunoperoxidase staining for calcitonin was negative. Notable electron-microscopic features included the presence of multiple neurosecretory granules with a dense core and halo, numerous free ribosomes, and no microvilli. The supraclavicular mass included lymph nodes and tumor extending into paralymphatic fat and connective tissue.

Both the serum calcium and PTH levels remained mildly elevated. Supraclavicular radiation therapy and fluorouracil and streptozocin chemotherapy for one year were given without change in the serum calcium or PTH values. A new right supraclavicular mass was excised in April 1986 and found to be fibrotic tissue without tumor. He was observed off therapy until recurrent pancreatitis with hypercalcemia prompted a neck exploration and the removal of a parathyroid adenoma in June 1988. The serum calcium levels returned to normal temporarily, but the pancreatitis recurred. Pulmonary nodules were discovered and removed in September 1989 and found to be recurrent carcinoid. He is now being treated with systemic infusional fluorouracil. Parathyroid hormone and serum calcium levels remain elevated, serum electrolytes are normal, and there have been no symptoms of flushing or diarrhea.

Discussion

Young age, an association with parathyroid tumors, male sex, prolonged survival, and the absence of the "carcinoid syndrome" are typical features seen in this and other patients with thymic carcinoid. The propensity for local and regional recurrences of the carcinoid, and our inability to definitively treat these patients with chemotherapy,[2] suggests that initial, aggressive surgical therapy, preferably through a sternal splitting incision, with complete removal of the thymus, should be carried out.

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Iatrogenic Illness

TO THE EDITOR: I just had the opportunity to read the medical staff conference on iatrogenic illness in the November 1989 issue.[1]

The comments and observations made by Dr Tierney are all important, but I wish to point out a major omission. Call it the sixth cause of iatrogenic illness, or maybe better yet, it should be called the first or second.

The medical profession has created illness where once it did not exist. We take persons with somatic complaints for which there are no objective findings and for which there is not a true organic lesion. A good history will reveal that this class of disease is stress-induced. The physician may recog-