does not answer the overriding question as to whether or not the screening has any value in terms of morbidity or mortality.

Furthermore, I am curious about the dynamic that prompted a prostate cancer screening program in a company the size of the Polaroid Corporation in Cambridge, Massachusetts. It would be interesting to note if this program was guided by scientific considerations or by overt and/or covert pressure from management to "do something."

Prostate cancer screening programs, particularly serum prostate-specific antigen evaluations, are seductive, and play to contemporary fears of cancer and particularly of cancer of the urogenital organs. Isn't it just this such seduction that led ten asymptomatic men to disfiguring urologic surgery and its attendant adverse impact on quality of life, for an undefined and questionable benefit?

I await with enthusiasm the suggested sequel to this paper that will examine the morbidity and mortality of the screened and nonscreened cohorts.

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The Author Replies: I reviewed Dr Berke's letter and his meaningful questions. These are the same questions, unfortunately, that were asked 20 years ago, and we still do not have answers. They will be the same questions asked 20 years from now unless the medical world and "men" gain further knowledge through scientific research.

The prostate-specific antigen test has flamed the controversy surrounding prostate cancer. Does early detection affect outcome? Are there two "types" of prostate cancer, each with a different natural course? What is the optimal treatment? How effective is treatment? The oncology world and "women" faced similar problems over the treatment of breast cancer. The information that we have about long-term survival after radical mastectomy vs less aggressive surgery would not be available if patients, oncologists, gynecologists, and internists had not made the difficult decision to undertake a study.

Now, urologists, radiologists, and oncologists must come together with patients to design and carry out a study on the results of various approaches to prostate cancer treatment. This requires overcoming any biases of what is the optimal or preferred treatment. Until then, the data we need will be unavailable.

As a further point, Dr Berke's comments erroneously suggest that prostate cancer is a benign disease. It is wrong to assume that "by extension," the 12 cancers that we discovered are clinically unimportant tumors. Several of the cancers had high Gleason numbers and had extensively spread within the capsule.

About 40,000 men die from this disease annually. These 40,000 men will not be concerned that prostate cancer can be an incidental finding at autopsy in elderly men or that prostate cancer does not compete for the cause of death in many cases. Their question will be, "Could this have been caught early while it was still curable?"

Our article was not designed to address optimal care or predict outcome of treatment. The paper was designed to: (1) determine the costs of discovering prostate cancer; (2) demonstrate a protocol that could be used by large corporations for screening; and (3) obtain a baseline statistic to help determine a comparison between screened and unscreened men to allow, in the future, an insight into whether morbidity and mortality are different between these two populations.

Employees with disease were referred to their primary care physician or urologist for decision and options regarding treatment.

The entire program cost $72,000. We discovered 12 cancers. If just one of those 12 patients were destined to be one of the 40,000 men who dies each year, the program would have been cost effective, considering the medical costs associated with a prostate cancer death (surgery, radiation, hospitalization, chemotherapy, etc). And, of course, even more costly are the years of productive life that are lost.

In summary, research is necessary to answer questions and settle the controversy surrounding prostate cancer. We hope that our study and article helped to add to the knowledge about prostate cancer and the viability of large-scale screening for this potentially serious disease.

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Reactive Airways Dysfunction Syndrome in a Nurse Exposed to Pentamidine

To the Editor: The article by Balmes et al[1] concerning occupational exposure to aerosolized pentamidine demonstrated the respiratory-tract irritant potential of inhaled pentamidine. The authors did not find clinical asthma in any of the subjects of their study, nor was occupational asthma reported in either of the other two studies that they cited, which had looked at the potential adverse health effects of pentamidine exposure among health care workers.

We would like to report a case of Reactive Airways Dysfunction Syndrome, or RADS,[2] in a 48-year-old nurse after she was acutely exposed to aerosolized pentamidine. The nurse was giving pentamidine through a nebulizer to an AIDS patient as a treatment for *Pneumocystis carinii* pneumonia

when the apparatus leaked and she inhaled the vapor. She immediately experienced difficulty breathing. Her symptoms persisted, and she was placed on asthma medications several months after this exposure. She had no history of asthma or allergies, and had stopped smoking more than 10 years before this exposure. She continued to have lower respiratory tract symptoms. Within a year, she left her job because of her illness. Pulmonary-function testing 2 years after the episode showed a 24% increase in FEV_1 after administration of a bronchodilator. At that time, she was still symptomatic and still taking asthma medications. The patient was reported by a physician (J.W.S.) to the SENSOR*

*SENSOR (Sentinel Event Notification Systems for Occupational Risks) is an occupational disease surveillance project funded by the National Institute for Occupational Safety and Health (NIOSH). NIOSH funds SENSOR projects in 14 state health departments.

occupational asthma surveillance system at the New Jersey Department of Health.

This case report underscores the potential for the development of RADS in health care workers after acute exposure to pentamidine, and it complements the finding by Balmes et al of the potential occupational exposure hazards of this medication.

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