CORRESPONDENCE

Inhaled Nitric Oxide in Preterm Infants — Correction

TO THE EDITOR: My coauthors and I wish to correct data reported in our article on inhaled nitric oxide in preterm infants undergoing mechanical ventilation (July 27, 2006).[1] During further data review, we found that one infant in the placebo group in whom bronchopulmonary dysplasia developed was incorrectly categorized as surviving without chronic lung disease. Nine additional infants were part of multiple births and thus received by design the same treatment as the earlier enrolled sibling. Because siblings share both genetic and in utero environmental factors related to the occurrence of chronic lung disease, they represent clustered data. Accordingly, we reanalyzed our data by means of the multiple outputation approach used in the original analysis and obtained a P value of 0.03 (relative benefit of nitric oxide in the overall population, 1.26; 95% confidence interval [CI], 1.02 to 1.55) rather than a P value of 0.04 (relative benefit, 1.23; 95% CI, 1.01 to 1.51), as reported in our article (in the Abstract, Table 2, and the third paragraph of the Results section). Analysis by means of the generalized-estimating-equations method,[2] which is also used for analysis of clustered data, gives a P value of 0.03 (relative benefit, 1.45; 95% CI, 1.03 to 2.04). In Table 2, the P value for survival among infants with a birth weight of 500 to 799 g should be 0.07 (relative benefit, 1.26; 95% CI, 0.98 to 1.62) rather than 0.14 (relative benefit, 1.20; 95% CI, 0.94 to 1.54). In the first paragraph of the Results section, the last sentence should read, "The 582 remaining infants had been delivered by 538 mothers (44 infants were assigned to a sibling's treatment)." In the third paragraph of the Results section, the first sentence should read, "In the group that was assigned to receive inhaled nitric oxide, 129 of 294 infants survived to 36 weeks of postmenstrual age without bronchopulmonary dysplasia (43.9 percent), as compared with 105 of 288 infants in the placebo group (36.5 percent)." The second sentence of the sixth paragraph of the Results section (related to data reported in Table 5) should read, "We observed a significant interaction between the age at study entry and treatment (P=0.005)," and the sixth sentence should read, "The effect of inhaled nitric oxide did not differ significantly according to race or ethnic group (P=0.06)" rather than "The effect of inhaled nitric oxide appeared to differ according to race or ethnic group (P=0.05)." These and other minor changes to the tables are listed in the Supplementary Appendix, available with the full text of this letter at www.nejm.org.

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THIS WEEK'S LETTERS

Since publication of the article, Dr. Ballard reports having received an honorarium and grant support from IKARIA/Inotherapeutics. No other potential conflict of interest relevant to this letter was reported.

1. Ballard RA, Truog WE, Cnaan A, et al. Inhaled nitric oxide in preterm infants undergoing mechanical ventilation. N Engl J Med 2006;355:343-53.
2. Liang K-Y, Zeger SL. Longitudinal data analysis using generalized linear models. Biometrika 1986;73:13-22.

Effect of Aircraft-Cabin Altitude on Passenger Discomfort

TO THE EDITOR: Muhm et al. (July 5 issue)[1] report that at a barometric pressure equivalent to an altitude of 8000 ft (2438 m) above sea level, participants in their study had a maximum decrease of only 4.4 percentage points in oxygen saturation, as measured by pulse oximetry. We are concerned about the accuracy in their setting.[2] To simulate high-altitude exercise in aircraft-cabin personnel, we examined 75 subjects between the ages of 24 and 62 years under normobaric, hypoxic conditions in a closed cabin with an oxygen content of 14.8%, the equivalent of conditions at an altitude

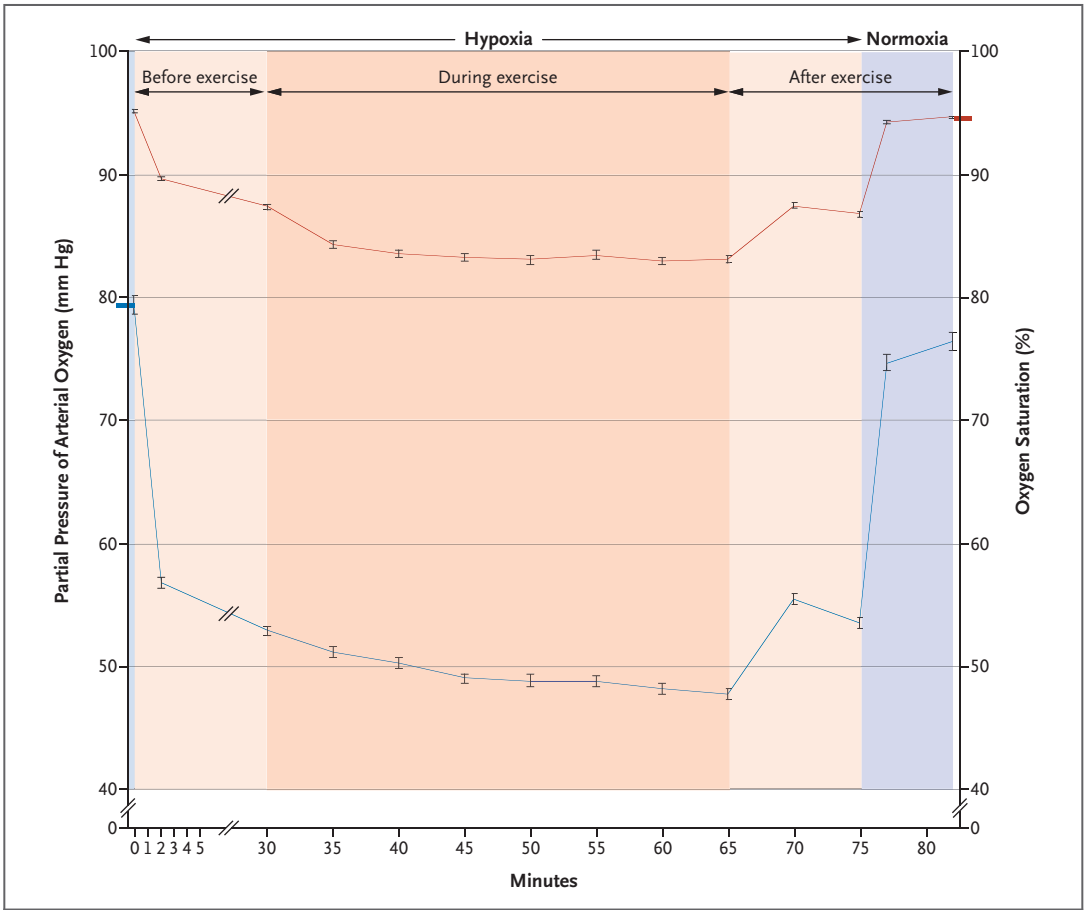

Figure 1. Comparison of Mean Oxygen Saturation and Blood Gas Analysis during Exercise under Hypoxic Conditions.

After 30 minutes under hypoxic conditions at a simulated altitude of 9186 ft (2800 m), 75 subjects were assigned to perform exercise (100-W cycle ergometry) for 35 minutes, followed by 10 minutes of rest and 10 minutes under normoxic conditions. Every 5 minutes, oxygen saturation values were measured (red line) and compared with the partial pressure of arterial oxygen (blue line) from arterialized earlobe blood. I bars indicate 95% confidence intervals.