Because there was a retrograde block in the SAN junction of the interpolated retrograde P waves, the retrograde limb of a SAN reentry in the SAN junction probably would also have been blocked. Therefore, it’s highly unlikely the NPs occur as a result of SAN reentry with a failure to depolarize the left atrium.

However, the NPs may represent right atrial depolarizations in left atrial P waves originating near the left atrial termination of BB (Fig 82) where the left atrial part of the P wave is not discernible.3

James J. Purcell, MD
Hartford, CT

Correspondence to: James J. Purcell, MD, 31 Woodland St, Hartford, CT 06105

REFERENCES

Mediastinal Hematoma Following Transbronchial Needle Aspiration

To the Editor:

Transbronchial needle aspiration (TBNA) mediastinal staging has gained increasing popularity in the last 2 decades because it may spare costs and morbidity of surgical procedures in many N2 and N3 cases in the setting of non-small cell lung cancer (NSCLC).1,2 The reported rate of complications is low (< 2% on average), and only anecdotal descriptions of major adverse events such as pneumothorax, pneumomediastinum, and severe infections can be found in a review of the literature.1 The occurrence of a mediastinal, periaortic hematoma following TBNA in the aortopulmonary window is herein reported.

A 57-year-old male smoker known to have NSCLC of the right upper lobe and an enlarged lymph node in the aortopulmonary window (suspected N3 disease) was referred for TBNA mediastinal staging. Since the aorta was inadvertently punctured with the 22-gauge cytology needle, the procedure yielded blood and caused acute posterior chest pain, as well as chills and sweat, leading to interruption of the examination. Arterial BP was found to be as high as 220/120 mm Hg. A contrast-enhanced CT scan performed minutes afterward showed a 1.2 × 1.8 × 4.3 cm periaortic hematoma (Fig 1). The patient had no alterations of clotting parameters. Complete, spontaneous resolution of either chest pain and CT evidence of hematoma occurred over a 1-week period.

Puncture of mediastinal great vessels is not uncommon in the practice of TBNA and is usually uneventful. Only one case of hemomediastinum suggested by radiography, notably occurring after TBNA in the aortopulmonary window, has been described.3 The protrusion of the aortic knob into the aortopulmonary window, in fact, makes it difficult to access this lymph node station, thus explaining the lower yields observed for TBNA performed in this station as compared with those in subcarinal and right paratracheal stations, and makes it easy to puncture the aorta.2,4 Our case confirms that clinically significant mediastinal bleeding may occur after TBNA, especially if a high-pressure vessel such as the aorta is punctured, even in patients without hemorrhagic risks, and in spite of using a small-bore cytology needle. We believe that patients with unexplained persistent and/or intense chest pain after puncture of mediastinal great

Figure 1. Continuous record of lead 2. Adapted with permission from Wanchun and Zhnouri.1

Figure 2. Recording of lead V1. Adapted with permission from Wanchun and Zhnouri.1
To the Editor:

Irritable Bowel Syndrome Might Be Appropriate Treatment for Medical Literature Implies Continuous Positive Airway Pressure Might Be Appropriate Treatment for Irritable Bowel Syndrome

The unknown cause of irritable bowel syndrome (IBS) limits patients to symptomatic treatment. However, information distributed throughout the medical literature does suggest a possible nonsymptomatic treatment for IBS. Articles1,2 that investigated the relationship between sleep disturbances and IBS reported an association of the two disorders. Altered bowel habits were statistically found to be, both temporally and unilaterally, secondary to sleep disturbances,3 thus implying sleep disturbance treatment might successfully treat IBS.

Of the six control subjects and six IBS patients who underwent sleep studies, observation of sleep apnea was limited to three patients.2 “In gut disorders, as in other unrelated conditions, the study of sleep apnea may provide important clues.”2

Effective treatment of a digestive disorder with a sleep-disorder treatment, while unusual, is not without precedence. Gastroesophageal reflux was successfully treated by utilizing continuous positive airway pressure (CPAP), a treatment for obstructive sleep apnea.2 Although this group postulated a mechanism involved in this treatment of reflux, a subsequent article4 by these researchers withdrew the postulate but not the report of CPAP eliminating reflux. A recent letter to CHEST (September 2001)5 describes a mechanism by which the common characteristic of upper airway resistance syndrome and OSA, violent diaphragm action during respiratory events, can cause gastro-esophageal reflux.

The concept of a single factor underlying comorbid disorders is surmised in a article6 studying the prevalence of IBS, reflux, and bronchial hyperresponsiveness. Those disorders were comorbid three times more often than expected:

One possible explanation is that the gastrointestinal and respiratory symptoms in our subjects are caused by a common (but as yet unidentified) underlying disorder, capable of producing symptoms in more than one physiological system and resulting in an indirect association between seemingly disparate conditions.6

Despite their inferior quality of life, IBS patients probably would be reluctant to participate in clinical tests of CPAP as a treatment for IBS due to its perceived inapplicability. However, the use of a typical screening questionnaire for sleep disorders and/or a sleep study may convince the patient of its applicability. Although CPAP will reduce symptoms, a positive pressure device that automatically adjusts to its perception of the patient’s needs will increase compliance and consequently improve treatment.

Joseph R. Herr, MS
Alamo, CA

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