was only observed at operation. The first case diagnosed by aortography was reported by Peretz et al.\textsuperscript{4} Our own case was also diagnosed by aortography.

A prosthetic valve or homograft can be inserted in the aortic root if there is a significant hemodynamic abnormality.\textsuperscript{4,5}

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Pulse Deficit during Ventricular Tachycardia

To the Editor:

Standard orders requiring both apical and radial pulse rate measurements are physiologically sound in patients with atrial fibrillation. The marked variability of cycle length, with attendant changes in diastolic filling and left ventricular stroke output, results in discrepancies between the timed apical beat and peripheral pulse, thereby effecting the "pulse deficit." We describe here such a pulse deficit in a subject with ventricular tachycardia, a 47-year-old man suffering from coronary artery disease. An unusual feature in this case was the slow and regular cadence of the radial pulse, which resulted in a "peripheral bradycardia."

Figure 1 shows the simultaneously recorded mitral area (MA) and tricuspid area (TA) phonocardiograms, external carotid pulse tracing (CT) and lead 2 (L2) of the patient's electrocardiogram. This demonstrates QRS complexes occurring at a rate of 150/minute, compatible with either of the following diagnoses: 1) ventricular tachycardia, or 2) A-V junctional tachycardia with aberrant ventricular conduction. Interestingly, according to the ECG (Fig 1), every third QRS complex resulted in a large deflection on the carotid pulse recording (pulses numbered 1-6). Palpation of the radial pulses revealed a regular rhythm and effective rate of 50/minute. Since the peak pulse amplitudes of the effective pulsations of our subject were almost equal in degree, the peripheral findings were consistent with a bradycardia. Palpation of the apex beat revealed a heart rate of 150/minute.

Examination of Figure 1 further indicates that only those QRS complexes preceded by identifiable P waves resulted in appreciable pulses. It can be surmised that the properly timed atrial contribution to left ventricular stroke output\textsuperscript{1} was operative in this subject. In addition, synchronization of the effective atrial contractions with those of the ventricles for every third beat resulted in a regular cadence to the pulse. Since ventricular tachycardia usually occurs in association with atrioventricular dissociation, jugular venous\textsuperscript{2} and arterial pulses\textsuperscript{3}
will vary with changing P-R intervals. The findings described in this report are rarely encountered but suggest that apical rates be routinely obtained in all cardiac patients.

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Antibiotic Regimen for Lung Abscess

To the Editor:

Although the use of oral antibiotics in the therapy of nonspecific lung abscess seems justified on the basis of the data of Weiss and Cherniack,1 one must more closely examine the therapy itself. The primary treatment of a lung abscess is adequate drainage, hydration, and relief of obstruction. Thus, postural drainage, chest physiotherapy, and bronchoscopy for diagnostic cultures and relief of obstructing plugs provide the main tools of therapy regardless of the route of antibiotic medication and administration of the case.

I recently reviewed 40 cases of nonspecific lung abscess at the University of California Hospitals, San Diego. All patients initially received penicillin or cephalosporin. Regardless of the antibiotic or route of administration, there was no difference in defervescence or fall in WBC.

I suspect that any oral antibiotic (penicillin, tetracycline, lincomycin, 7-chlorolincosmycin) would be as effective as parenteral antibiotic therapy just because antibiotics are not the mainstay of the therapeutic regimen.

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To the Editor:

I agree with Dr. Barker that adequate drainage is important in the management of lung abscess. However, in most cases the bronchial obstruction is inflammatory and the antibiotic rather than mechanical therapy or hydration relieves the inflammatory obstruction. Fifteen of our 36 patients were examined by bronchoscopy, but the results were equally good in those who were not subjected to bronchoscopy. I have treated many other patients with lung abscess prior to our controlled clinical trial and several who were given small doses of oral penicillin G by house staff in error showed no clinical response until the dose was increased to 1.2 million units four times a day.

Without a controlled clinical trial it is not justifiable for Dr. Barker to conclude from his observation that antibiotics are not the mainstay of the therapeutic regimen. The fact that different antibiotics given by different routes result in cure of lung abscess may be interpreted as follows: all the antibiotic regimens tried are effective.

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Cavitation in Histoplasmosis:
Some Further Comments

To the Editor:

In an editorial in a recent issue of Chest,1 Drs. Chick and Bauman, from the University of Kentucky College of Medicine, raised some interesting points about the cavitation seen in histoplasmosis. Although they have emphasized that the acute appearance of cavitation is a part of the spectrum and that it may suggest some immune response abnormality, it should be kept in mind that the appearance of a cavity on an x-ray can be explained by a variety of pathologic events.

In general, cavities may be seen in three situations. When primary infection occurs, there is an area of granulomatous inflammation with central necrosis in the pulmonary focus (foci). If this area is large, it may, in as little as three to four months, in my experience, become inspissated and somehow be extruded from the focus, leaving a cavity.

Reference