review the problem of computerized electrocardiographic terms and criteria. As chairman of this subcommittee, I plan to address members of the faculty committee to this type of question.

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Turner's Syndrome and Aortic Aneurysm

To the Editor:

It is well known that about one-third of the patients with Turner's syndrome have coarctation of the aorta; however, only a relatively small number of patients with Turner's syndrome and coarctation of the aorta have been found to also have an aortic aneurysm. Patients with Turner's syndrome and aortic aneurysm but without coarctation of the aorta have been documented even less frequently. We would like to report another case of the latter type.

CASE REPORT

An 18-year-old white woman with an XO sex-chromosome constitution is being followed in the pediatric endocrinology clinic following the initiation of exogenous estrogen therapy. No cardiac murmur was noted prior to beginning the hormone regimen, and a cardiac evaluation seven years earlier remains to be defined. The experience with our patient would lead us to ask whether exogenous estrogen therapy might trigger the development and progression of great-vessel connective-tissue abnormalities in some patients with gonadal dysgenesis.

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REFERENCES
5 Dorfman A, Schiller S: Effects of hormones on the metabolism of acid mucopolysaccharides of connective tissue. Recent Prog Horm Res 14:427, 1958

More Female Smokers: More Female Lung Cancer

To the Editor:

During the last year, there have been many discussions in Chest about smoking women and lung cancer. Recently, Wynder et al presented a retrospective study of 108 female lung-cancer patients during 1970 to 1972 and showed that cigarette smoking was closely associated with epidermoid and anaplastic lung cancer and less strongly with glandular types of lung cancer. As women adopt cigarette-smoking habits similar to those of men, these investigators propose that the death rates from lung cancer in women will continue to increase.

We recently have seen a heavy-smoking 19-year-old woman dying because of a small-cell anaplastic lung cancer.

CASE REPORT

Except for cystitis, this 19-year-old woman had always been healthy. She started to smoke at the age of 13 years and continued to smoke 20 to 30 cigarettes or more daily. During her last two years, the patient had a cough; and after a common cold in July 1974, her cough increased. In January 1974 the patient became pregnant, and in September she bore a healthy child. A chest x-ray film at that time showed a large tumor in the patient's left lung. At that time, she already had metastatic destruction in the spine. A chest x-ray film one year earlier was normal. Histopathologic and cyto logic examination of material obtained by fiberoptic bronchoscopic techniques and fine-needle aspiration biopsy showed a small-cell anaplastic lung cancer. In spite of radiotherapeutic and cytostatic treatment, the patient died two months after the delivery of her child. Autopsy confirmed the diagnosis.

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D I S C U S S I O N

The frequency of lung cancer in women in Sweden tends to increase. During the period of 1958 to 1971, the incidence of new cancers in the trachea, bronchus, lung, and pleura per 100,000 inhabitants of all ages was as follows: 1958, 6.0; 1959, 5.4; 1960, 5.2; 1961, 5.2; 1962, 7.0; 1963, 6.4; 1964, 7.0; 1965, 7.8; 1966, 6.5; 1967, 7.5; 1968, 8.2; 1969, 9.2; 1970, 9.6; and 1971, 9.3.

The frequency of lung cancer in women below the age of 30 years in Sweden (9 million inhabitants) is low. During the period of 1958 to 1970, only 16 cases were reported to the Swedish Cancer Registry.

In Sweden the cigarette consumption has increased from about 200 to 1,600 cigarettes per year per inhabitant above 15 years of age during the last 50 years. In recent years, there has been a rapid increase in the number of smoking women. In a sample test in Gothenburg, Sweden, in 1971, 56 percent of girls 15 to 19 years of age were smokers.

In the present case, we believe that cigarette smoking played an important role in the development of lung cancer. Perhaps altered immunologic conditions during the pregnancy were contributory. Unless there is a marked decrease in smoking habits in the future, we can expect an increasing number of lung cancers in women and perhaps also in young girls.

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R E F E R E N C E


Corticosteroids for Myocardial Infarction and Pericarditis

To the Editor:

In the article entitled "Pericarditis of Acute Myocardial Infarction" (Chest 67:647-653, 1975) by Toole and Silverman, the authors' routine use of corticosteroid therapy for the symptomatic relief of patients with myocardial infarction and pericarditis deserves some comments.

Pericarditis early in the course of acute myocardial infarction is usually a benign self-limiting process, the symptoms of which can well be controlled with administration of either aspirin or indomethacin. On the other hand, corticosteroid administration has been shown to have deleterious effects on the cardiovascular system, including an increase in blood pressure, and retention of sodium and fluids. There are no well-controlled studies on the following factors: (1) the effects of steroid therapy in the early phases of healing in acute myocardial infarction; (2) the incidence of postmyocardial-infarction syndrome and the administration of steroids in the early stages of myocardial infarction and pericarditis; and (3) the effect that steroid therapy has in increasing blood coagulability, particularly when the risk of thromboembolic phenomena is high.

In view of the possible adverse effects of corticosteroid therapy on the cardiovascular system, and until further studies reveal the effects of corticosteroid therapy in acute myocardial infarction, corticosteroids should not be included in the first line of drugs for symptomatic treatment of pericarditis.

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R E F E R E N C E S


To the Editor:

Dr. Missri's comments reflect a controversy that has been bobbing to the surface for 25 years. Despite the known disadvantages of corticosteroid therapy, a number of studies have reported a beneficial effect on the morbidity, mortality, and size of myocardial infarction.

In our experience, pericarditis is a significant complication. The pain is often considerable; and the patient is uncomfortable, unable to rest, and frightened that another infarction has occurred. Respiration is often shallow, and hypoxia may occur. Administration of narcotics is generally ineffective, even in substantial doses which may produce potent side effects. Corticosteroid therapy, on the other hand, affords quick and often prolonged relief, allowing the patient to rest and breathe comfortably. Administration of aspirin and indomethacin may