hydrocortisone for 53 of 63 days after myocardial infarction. At autopsy, it was noted that the healing had been slowed to the 10- to 14-day level after infarction, with development of a large ventricular aneurysm. These investigators also cited several reports supporting the detrimental effects of corticosteroid therapy in delaying healing and in the formation of aneurysms after infarction in both humans and animals. It is interesting that in the paper by Toole and Silverman, three of their six autopsied cases had ventricular aneurysms; however, it is not stated whether these patients had received steroid therapy.

In light of these observations, the use of steroid therapy for a probably self-limited condition may be unwarranted when less toxic analgesic and anti-inflammatory agents are available. It seems unlikely that the questionable benefit of decreased narcotic use in this setting justifies the risk of delayed healing of the infarct and aneurysm formation.

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REFERENCE

1 Bulkley BH, Roberts WC: Steroid therapy during myocardial infarction. Am J Med 56:244-250, 1974

Interpretation of Chest X-ray Films

To the Editor:

The lead article in the September issue, “Disagreements in Chest Roentgen Interpretation” by Herman et al (Chest 68:278-282, 1975), is right on target. Responsible radiologists have been very honest about the problems in proper interpretation of chest films. Perhaps if more clinical information and the patient’s age and sex had been given, the authors’ interpretation accuracy would have been higher. Nevertheless, several points must be emphasized: (1) responsible radiologists are keenly aware of problems in film interpretation; (2) when ordering a chest film at most institutions, you are asking for a radiologist’s consultation, and this should be carried out as other forms of medical consultation, with dialogue between physicians, adequate clinical information, etc; (3) it is irresponsible for the referring physician to request a chest film without supplying adequate clinical information; and (4) a written radiologist’s report is not equivalent to tissue diagnosis.

It is my impression that practicing physicians, particularly on the primary-care level, do not listen to the radiologists discuss their own problems with chest film interpretation and simply rely on a typewritten report as the be-all and end-all. A patient with chest symptoms and abnormal findings on the chest film needs careful interpretation and consultation on his chest film. Dr. Herman and his colleagues have written an honest, straightforward prospective report, and its implications and conclusions need strong emphasis before the community of practicing physicians.

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Phlebotomy, Hemodilution, and Autologous Transfusion in Open-Heart Surgery

To the Editor:

I would like to compliment Cohn and associates on their article entitled “The Effects of Phlebotomy, Hemodilution and Autologous Transfusion on Systemic Oxygenation and Whole Blood Utilization in Open Heart Surgery,” which appeared in the September 1975 issue (Chest 68:283-287, 1975). This is certainly the correct approach, and I am sure it is not only beneficial to the patient, but also helps to save on the amount of blood used for open-heart surgery.

Since late 1972, we have used phlebotomy, hemodilution, and then replacement of the blood from the heart-lung machine to the patient. We then return to the patient his own blood that was withdrawn prior to cardiopulmonary bypass. By using such a technique for the last 726 consecutive patients who had vein graft surgery, 80 percent received no blood during the operative procedure nor at any time during their hospitalization. For those patients undergoing valvular surgery alone, 140 (65 percent) of 214 patients received no blood. And, for those having valvular surgery along with vein graft surgery, 132 (54 percent) of 244 patients received no blood. The technique was published in our article entitled “Coronary Artery Surgery: A New Technique with Use of Little Blood, If Any,” which appeared in the August 1974 issue of The Journal of Thoracic and Cardiovascular Surgery (68:283-287, 1974). We believe that this technique is now a proven one, and we strongly urge other cardiac surgeons to use it.

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Sterilization of the Flexible Fiberoptic Bronchoscope

To the Editor:

I have read the letters from Dr. Johnson and from Dr. Miner entitled “Sterilization of the Bronchoscope” (Chest 68:607, 1975).

I would like to answer them as follows: My original article in Japanese covered nine pages of report and references, including some about 2-bromo-2-nitropropane-1,3-diol (Bronosol; bronopol). The version printed in Chest was very much condensed and, therefore,