7 Zoll PM: Countershock and pacemaking in cardiac arrhythmias. Hosp Practice, 1975, pp 125-132

Unusual Allergic Reactions to Biting Insects

To the Editor:

Again this year I am compiling a Biting Insect Summary and would appreciate any case reports of unusual allergic reactions, especially systemic reactions (sneezing, wheezing, or urticaria) to bites of insects, ie, mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sand flies, deerflies, etc.

I would like physicians to supply me with case reports of those patients who have had unusual reactions to such insects. Include in your reports the type of reactions (immediate and delayed symptoms), treatment, the age, sex, and race of the patient, the site of the bite(s), the season of the year, and any other associated allergies.

If skin tests and hyposensitization were instituted, I would like the report of both. Please note that it is the biting (not stinging) insect in which I am interested.

If you have found any insect repellent, local treatment, or insecticides of value, I would also appreciate knowing this.

Please send this information to the following address: Claude A. Frazier, M.D.; 4-C Doctors Park; Asheville, NC 28801.

Claude A. Frazier, M.D., F.C.C.P.
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Congenital Pericardial Defects and Cardiac Herniation

To the Editor:

The report by Robin et al1 of strangulation of the atrial appendage through a congenital pericardial defect draws attention to this unusual abnormality. As stated in the article, recently the diagnosis of pericardial defect is being made more frequently before the death of the patient.

Although there is obviously an asymptomatic phase, clinical presentations after herniation have included chest pain with acute cardiovascular collapse,1 periph-
eral emboli,2 pericarditis,3 and sudden death.4,5 In view of these complications, surgery would seem desirable in the asymptomatic case and mandatory once strangulation of one or more of the chambers of the heart has occurred. The chest radiographic appearances are strikingly similar once cardiac herniation has occurred,1,3,6-9 and systolic murmurs have been described before and after atrial strangulation.1,3 The degree of abnormality of the cardiac silhouette on the x-ray film is presumably governed by the amount of herniating tissue; this may be seen on routine chest x-ray films.3

A considerable number of cases have now been described, and perhaps the diagnosis of cardiac herniation through a pericardial defect should be entertained in children, adolescents, and young adults with atypical chest pain with or without circulatory collapse. It is in this group, and usually in males, that this anomaly and its complications have been seen. Despite the variable clinical picture, chest roentgenograms give much help in diagnosing this condition.

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REFERENCES

4 Sunderland S, Wright-Smith SJ: Congenital pericardial defects. Br Heart J 6:167-175, 1944

Chicken Soup and Relief of Backache

To the Editor:

I note with interest the recent exchange of views in Chest on the therapeutic value of chicken soup.1 As the spouse of a Frau born in interbellum Berlin, I am naturally well acquainted with the presumptive virtues of the product. Only yesterday I was complaining of the malaise of latissimus and rhomboid muscular strain induced by a full day of swinging a pickaxe almost futilely at the layer of caliche in the flower bed. My wife ten-
dered me in sympathy a bowl of the tasty concoction. "Will it help me?" "No, but it won't hoit'cha."

Lest it be considered that chicken soup has some sort of monopolistic preeminence in thoracic therapeutics, I would like to record for the benefit of science a similar product of distinctly different origin. In the course of auditing outpatient records, I have noted recently that a colleague is obtaining excellent results in alleviating the tussive discomfort of influenza by prescribing "terrapin hydrate." He must be a Baltimore graduate, and I assume that he refers to that delicious Maryland decocion known loosely as "turtle soup."

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REFERENCE

1 The chicken soup controversy. Chest 68:604-606, 1975

Tuberculosis after Intestinal Bypass Surgery for Obesity

To the Editor:

I have recently encountered two instances in which patients broke down with active tuberculosis following intestinal bypass surgery for obesity.

CASE REPORTS

CASE 1

This patient was mildly diabetic and weighed 136 kg (300 lb); a 13-mm induration had occurred on a Mantoux test in 1963. In 1973, intestinal bypass surgery was performed, with the patient subsequently losing over 45 kg (99 lb).

In 1974, an osteolytic lesion developed in the right calcaneus, which was curetted and showed granulomatous inflammation with many areas of caseation and Langhans' giant cells. Special stains were reported as showing "no definite acid-fast bacilli." Tissue had not been sent for culture, nor was positive for Mycobacterium tuberculosis.

Chemotherapy was given, and a repeat biopsy after 3% months showed only atrophic dermal scar with foreign-body giant-cell reaction and no evidence of caseation. Healing has proceeded, albeit slowly.

CASE 2

This patient also weighed 136 kg and lost 56 kg (123 lb) after intestinal bypass surgery in the spring of 1974. In the fall of 1975, the induration from a skin test was 15 mm, changes in the chest x-ray film developed, and the sputum was positive for Mycobacterium tuberculosis.

DISCUSSION

These cases add to the recent report of Pickleman et al., who have suggested that this type of occurrence might well be another of the special clinical situations of lowered resistance in which tuberculosis might develop. As it is most likely to be breakdown in a previously infected patient, preoperative assessment and preventive treatment may well be indicated.

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REFERENCE


Tracheobronchial Suction Catheters

To the Editor:

I have read with great interest the report by Jung and Gottlieb entitled "Comparison of Tracheobronchial Suction Catheters in Humans: Visualization by Fiberoptic Bronchoscopy," which appeared in the February 1976 issue (Chest 69:179-181, 1976). On the basis of the data presented by Jung and Gottlieb, I must take issue with two of their conclusions, the first of which appears in the abstract, and the second in the final paragraph, viz: (1) "Mucosal trauma with tracheobronchial suctioning procedures is more likely due to repetition, vigor, and amount of suction applied, regardless of which type of catheter is used" (italics mine); and (2) "... trauma seen with repeated suctioning procedures in the respiratory tract is created not only by a specific design or the material from which a suction catheter is made, but that probably equally important are the frequency, vigor of insertion, duration of uninterrupted suction, and the present vacuum level, all of which predispose to injury regardless of what type of catheter is used" (italics mine).

Jung and Gottlieb recognize that trauma to the airways occurs in patients undergoing suction over prolonged periods but have not done the proper experiments to arrive at these two speculative conclusions. First, they premedicated the patients with atropine, an agent known to depress mucociliary clearance, thereby inducing conditions which might alter visual observations; and secondly, they applied intermittent suction for 10 to 15 seconds and repeated it two to three times (presumably at the same site), an experimental design which does not duplicate the degree and duration of time for suctioning carried out in the clinical arena. Unless Jung and Gottlieb repeated the suctioning a sufficient number of times to produce such damage to the bronchial mucosa, as described by Sackner et al., and found equal severity of damage by the Aero-Flo, single-eyed, and two-eyed catheters, their conclusion that design of the catheter is not as important as the other factors they cite is a non sequitur. Certainly, such a study is difficult to undertake and is one which might violate human rights in patients, since there is evidence in