Pertussoid Eosinophilic Pneumonia

To the Editor:

In the April 1977 issue of Chest, Oetgen1 reported four cases of “pertussoid eosinophilic pneumonia” in young infants (6 weeks to 3 months of age). All of the children had a persistent cough, tachypnea, peripheral eosinophilia (eosinophils, 8 to 22 percent), an elevated concentration of IgM, and an extensive bilateral interstitial pulmonary infiltrate. No etiologic agent was identified.

Beem and Saxond reported 47 infants (4 to 24 weeks of age) with findings essentially identical to the cases reported by Oetgen.1 In all of the patients of Beem and Saxon,2 either Chlamydia trachomatis was cultured from the trachea, or the patient had a substantial rise in the titer of antibodies to C trachomatis.

We would like to suggest that at least some of the cases of pertussoid eosinophilic pneumonia described by Oetgen may very well represent pneumonia due to C trachomatis. Physicians who see such a patient should obtain appropriate cultures and serologic studies for Chlamydia.

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REFERENCES

Editor’s Note: Similar comments were received from Stephen A. Whaley, M.D., and Joanna J. Siebert, M.D., Departments of Pediatrics and Radiology, University of Arkansas Medical Center, Little Rock.

Electrocardiographic Artifact Caused by Pacemaker Pulse-Width Controller
Simulation of Ventricular Arrhythmia

To the Editor:

A recent attempt to prolong the life of permanently implanted electronic pacemakers has been made by shortening the duration of the electrical impulse emitted by the pulse generator, thereby reducing the drain of current from the battery.3 Shortening of the width of the generated pulses may be accomplished externally with a hand-held pulse-width controller. This communication describes an electrocardiographic artifact that may simulate a ventricular arrhythmia when the device of a hand-held pulse-width controller is used.

CASE REPORT

The patient was a 22-year-old woman with surgically induced complete heart block who was admitted for a change of her pulse generator. Her previously implanted unit was re-
The faster the bar magnets are rotated, the greater the height and frequency of the artifact (Fig 1). Unless the operator is aware of this phenomenon, the wave form of this artifact may be confused with a ventricular arrhythmia. In our case, it was possible to be reasonably certain that the electrocardiographic abnormality was an artifact and not ventricular tachycardia for three reasons: (1) the abnormality occurred only during the turning of the hand crank; (2) the height and frequency of the artifact both increased as the speed of cranking was accelerated; and (3) the morphologic appearance of the artifact (as noted in the bottom strip of Fig 1), with its narrow width and frequency of 660/min, is inconsistent with ventricular tachycardia.

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REFERENCES

Premature Closure of the Mitral Valve
Echocardiographic Clue for the Diagnosis of Aortic Dissection

To the Editor:

In chronic aortic regurgitation the dilated left ventricle can accommodate large diastolic volumes without a significant rise in end-diastolic pressure, while in acute aortic regurgitation, there is marked elevation of the left ventricular end-diastolic pressure, often exceeding the left atrial pressure. This hemodynamic pattern results in premature closure of the mitral valve. Recently, we identified premature closure of the mitral valve by echocardiographic studies in two patients with dissection of the ascending aorta and severe aortic regurgitation.

Case Reports

Case 1

A 38-year-old man with a known murmur of aortic regurgitation for one year was hospitalized after several days of severe pain in the chest and shortness of breath. His blood pressure was 120/40 mm Hg, and the pulse rate was 110 beats per minute. A grade-4/6 systolic ejection murmur and a grade-4/6 decrescendo diastolic murmur were heard over the aortic area, radiating to the rest of the precordium. Cultures of blood were negative.