of saphenous vein were used to bypass parts of the left anterior descending and the circumflex coronary arteries. The patient was discharged on May 13, 1976 while doing well; however, he returned to the hospital on June 21, 1976, with severe congestive heart failure that was unresponsive to medical management.

On July 20, 1976, cardiac catheterization and left ventriculographic and coronary angiographic studies were done. The diastolic pressures in the right ventricle and the pulmonary artery, the pulmonary arterial wedge pressure, and the right atrial pressure were all equal and were approximately 22 mm Hg. The venous grafts were patent. The ventriculogram showed a small left ventricle. A presumptive diagnosis of constrictive pericarditis was made.

On July 27, 1976, a pericardiotomy was attempted. Injury to the ventricular walls as well as to the coronary arteries occurred as a cleavage plane could not be established. The patient died of "low cardiac output syndrome" on the day following the operation. Histologic examination of the removed tissue revealed a spindle cell thymoma invading the myocardium.

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Acute Epiglottitis

The Use of a Fiberoptic Bronchoscope in Diagnosis and Therapy

To the Editor:

Acute epiglottitis in adults has remained a difficult therapeutic challenge, with significant morbidity and mortality. Although the diagnosis can be made by several means, immediate therapy is often necessary to maintain the patency of the upper airways. In the following case report, we outline an approach that will allow immediate diagnosis and therapy with the use of the fiberoptic bronchoscope.

CASE REPORT

A 48-year-old woman was admitted to the hospital with obvious stridor. She had become acutely ill 34 hours prior to admission and had been treated with tetracycline for infection of the upper respiratory tract. Dyspnea had been progressive over the last 12 hours and was unabated by the upright position. Physical examination revealed an acutely ill patient with stridor both on auscultation and inspection.

Immediate evaluation of the upper airways was performed with the use of the fiberoptic bronchoscope (Olympus BF-B2) via the transnasal route. The epiglottis was visualized without difficulty and was hemorrhagic (cherry red), consistent with acute epiglottitis. Edema and hemorrhage were diffusely present in the supraglottic area, and the larynx was almost totally occluded by the enlarged epiglottis.

The bronchoscope was then introduced past the area of obstruction through the vocal cords into the upper one-third of the trachea. A nasotracheal tube (Portex) (Fig 1) had been inserted over the fiberoptic bronchoscope prior to its introduction into the nares. Once the obstruction in the upper airways had been bypassed with the bronchoscope, it was relatively easy to advance the tracheal tube over the bronchoscope and into the trachea. Once intubation was completed, the bronchoscope was removed, and the patient was transferred to the intensive care unit while in a stable condition. The total time for the procedure was 15 minutes.

Cultures of blood were subsequently positive for Hemophilus influenzae, and therapy with ampicillin was begun on admission. The course of the patient's illness after intubation was uneventful, and tracheal extubation was performed on the third day of hospitalization.

DISCUSSION

Obstruction of the upper airways due to acute epiglottitis in adults is indeed both a medical and often a surgical emergency. Although this condition may be treated conservatively, the significant mortality and morbidity would demand that the disease be treated in an urgent fashion.

We believe that the fiberoptic bronchoscope incorporates an immediate and direct visualization of the upper airways, as well as the means to definitively treat this patient, i.e., to relieve the obstruction of the upper airways with intubation. This is the major advantage of this approach. Other benefits include better acceptance by the patient, less trauma to tissues, and the relative ease in performing this procedure with the patient in the upright position, thus theoretically avoiding the posterior displacement of the epiglottis over the compromised upper airway. Lastly, no anesthesia is required for placement of the tube. The potential problems with this
approach would include the need for an experienced endoscopist to perform this procedure and the availability of the endoscopist in the urgent situation of acute epiglottitis. In summary, we believe that this procedure represents the diagnostic and therapeutic approach of choice in the treatment of acute epiglottitis in adults.

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REFERENCE


Cell-Block Preparation for Cytodiagnosis of Pulmonary Paracoccidioidomycosis

To the Editor:

Sanders and associates\(^1\) have reported interesting findings regarding the diagnosis of pulmonary blastomycosis by the presence of Blastomyces dermatitidis in smears of bronchial washings stained by Papanicolaou’s technique. These investigators\(^2\) emphasized the cytologic technique as a good auxiliary method in differentiating pulmonary neoplasms from blastomycosis, thus reducing the need for diagnostic thoracotomies.

We have been applying the same procedure for the cytologic diagnosis of pulmonary cases of paracoccidioidomycosis, a deep mycosis caused by Paracoccidioides brasiliensis, which is a very common endemic disease in Brazil and several other Latin-American countries. From samples of sputum from patients suspected of having pulmonary paracoccidioidomycosis, we have been making both Papanicolaou’s smears and cell-block preparations.\(^2\) Our experience indicates that cell-block preparation improves the cytodiagnostic accuracy tremendously. Cell blocks have the advantage of enabling study of serial sections, which can be stained either by routine procedures or by specific stains for fungi (Gomori’s stain or PAS stain).

Sometimes in Papanicolaou’s smears, it is difficult to diagnose with certainty the presence of the fungi. In contrast, in the cell block the following two diagnostic features become readily identifiable: (1) P. brasiliensis, either in the cytoplasm of macrophages or free among inflammatory cells (it is noteworthy that the fungi are characterized by multiple budding,\(^3,4\) which is easily documented by Gomori’s or PAS stains); and (2) the presence of epithelioid granulomata, sometimes containing epithelioid cells (Fig 1).

In an endemic area like South America, procedures improving the diagnosis of paracoccidioidomycosis are always welcome. Since the disease can affect exclusively the lungs and since the serodiagnostic tests may give false-positive cross-reactions with other deep pulmonary mycoses,\(^5,6\) we believe that cytologic study of sputum from patients suspected of having paracoccidioidomycosis can be of great diagnostic help. We would like to emphasize that cell-block preparations yield good and representative sections of the material and allow easy and ready demonstrations of the fungi.

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212 COMMUNICATIONS TO THE EDITOR

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