Massive Tumor Embolism

To the Editor:

In the article entitled “Myocardial Infarction due to Tumor Embolization following Pulmonary Resection,” Karlsberg et al have addressed the problem appropriately but have failed to cite the publication in 1962 by Senderoff and myself on the same problem of massive tumor embolism. While we did not perform a pulmonary resection in our patient (which is the reason why our article is entitled “Massive Tumor Embolism during Pulmonary Surgery”), we made the correct diagnosis of tumor embolism to the femoral artery after thoracotomy and confirmed it by operation. Also, the entire clinical and pathologic entity was discussed and the literature extensively reviewed. We made suggestions about handling extension of tumor into the atrium commensurate with the level of technical expertise available in 1962. We also referred to a report by Nohl, who actually removed an intra-atrial polypoid extension of tumor without cardiopulmonary bypass.

Since then, I have performed surgery on at least four patients with lung cancer in whom complete tumor occlusion of the superior or inferior pulmonary vein was noted. The vein was divided at the atrial level, without “back bleeding.” None of these patients demonstrated embolic phenomena, and one is still alive 20 months later (radiotherapy having been given after surgery).

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REFERENCES


Factitious Bradycardia and Hypotension due to Surreptitious Ingestion of Propranolol

To the Editor:

Propranolol, a widely prescribed β-adrenergic antagonist, may cause bradycardia and hypotension with both therapeutic dosages and intentional overdose. We recently saw a patient with symptomatic bradycardia and hypotension due to surreptitious ingestion of propranolol, from whom no history of its use could be obtained.

CASE REPORT

A 36-year-old nurse was hospitalized in late 1977 for evaluation of pain in the chest. She had had diabetes mellitus requiring therapy with insulin since the age of 27 years but otherwise had been in excellent health until mid-1975, when she began having syncopal episodes. The patient described these as nonpositional “drop-attacks” occurring two to three times a month without prodrome and followed by squeezing substernal pain in the chest. On three occasions prior to this admission, she had been hospitalized for diagnostic evaluation of these symptoms. Extensive neurologic and endocrinologic studies revealed no abnormalities. Prolonged electrocardiographic monitoring demonstrated only sinus bradycardia. Carotid ultrasonic and coronary arteriographic studies revealed normal findings. Therapeutic trials of quinidine, procainamide hydrochloride, propranolol, and nitroglycerin failed to prevent subsequent episodes of this syndrome of syncope and pain in the chest and were discontinued.

At the time of this most recent admission, the patient complained of severe crushing pain in the chest preceding, for the first time, a typical syncopal attack. She repeatedly denied taking any medication other than her insulin since her recent therapeutic trials of antiarrhythmic drugs had been discontinued several months before. The physical examination revealed a regular heart rate of 50 beats per minute and a blood pressure of 90/45 mm Hg without postural change. The results of laboratory evaluation were normal, including a blood glucose level of 92 mg/100 ml.

During the next several days the patient’s heart rate varied from 36 to 60 beats per minute, and blood pressures as low as 70/40 mm Hg were recorded. She had several syncopal events and spent much of her time in bed.

We enjoyed reading the article by Senderoff and Kirschner that was published in 1962; however, since their case did not actually involve pulmonary resection, it would not have been included in Table 1 of our article. There were many cases of embolization of tumor from causes other than actual pulmonary resection which we did not include. We attempted to make this article brief by limiting our review to cases which specifically dealt with pulmonary resection.

Nevertheless, the article by Senderoff and Kirschner is pertinent to our work and would certainly have been relevant to our review and discussion 18 years later. The technique that they suggested in 1962 is similar to what we currently recommend; however, since we routinely use cardiopulmonary bypass, we would still recommend cardiopulmonary bypass when studies such as computed tomograms suggest left atrial extension.

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