To the Editor:

I do not agree with Hooper and Beechner that a history and physical examination plus routine laboratory data are sufficient pre-thoracotomy workup for a patient with apparently localized lung cancer. A recent paper by Kelly et al in JAMA (Efficacy of Radionuclide Scanning in Patients with Lung Cancer; 1979; 242:2855-57) summarizes the case for radionuclide scanning in patients with lung cancer: seven of 38 patients (18.4 percent) with no clinical evidence of metastatic disease to liver, brain, or bone had at least one type of abnormal study at these sites felt to be indicative of occult metastasis. If a minimally elevated alkaline phosphatase level was considered an indicator of metastasis, then four of 41 patients (9.8 percent) had evidence of occult metastasis by radionuclide scans. As in other series cited by these authors, bone scans were by far the most sensitive. It should be noted that gallium scans were not performed routinely in Kelly's series, and I'm sure Dr. Mintz would argue that the performance of this procedure, at least with his "Tomocan" scanner, might increase the yield significantly further. In many institutions, CT brain scans (also not included in Kelly's series) are now replacing radionuclide brain scans as a "screening" procedure in cancer patients felt to be at high risk for occult metastasis to that site. Whether they will be significantly more valuable than the older scan to justify their routine use remains to be seen.

My own personal approach has been to perform only the technetium bone scan as a "screening" maneuver in the patient with lung cancer which appears potentially resectable by history, physical examination, laboratory tests and chest x-ray film. For patients with large cell anaplastic and adenocarcinoma of the lung, CT brain scan is a recent addition for which I can offer justification only prospectively.

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Lack of Effect of Erythromycin on Theophylline Serum Levels

To the Editor:

In a recent editorial by Van Dellen (Chest 1979; 76:2-3) discussing the use of intravenous aminophylline, the author states that "...the half life (of theophylline) is prolonged in cases of ingestion of troleandomycin and erythromycin." While the inhibition of theophylline clearance by troleandomycin is well documented, the effect of erythromycin on theophylline plasma levels is not well defined.

Although some reports have pointed to an increased theophylline plasma level in children with concomitant erythromycin administration, a recent study of adult subjects by Pfeifer et al found no consistent evidence of a kinetic interaction between orally administered erythromycin and intravenous theophylline. Additionally, in an as yet unpublished study from our laboratory we found no statistically significant effect of oral erythromycin on theophylline plasma levels in eight normal adult volunteers. Therefore, our preliminary data are not consistent with those of earlier studies, and warrant further examination of the clinical and scientific significance of the potential drug interaction of erythromycin and theophylline.

It would appear that the effect, if any, of erythromycin on theophylline serum levels has yet to be determined.

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REFERENCES


Persistent Contamination of the Flexible Fiberbronchoscope following Disinfection in Aqueous Gluteraldehyde

To the Editor:

In 1975, Webb and Vall-Spinosa (Chest 88:703-708, 1975) reported an outbreak of Serratia marcescens associated with the flexible fiberoptic bronchoscope. The persistence of Serratia in the bronchoscope was attributed to an ineffective cleaning technique. Adoption of a revised procedure ended the outbreak, and no further infections related to bronchoscopy were identified.

At The New York Hospital Burn Center, we recently recovered strains of Serratia marcescens, Klebsiella pneu-

miae, and Pseudomonas aeruginosa from an Olympus fiberoptic bronchoscope after cleaning both according to a method similar to the revised Webb and Vall-Spinosa procedure and the Olympus instructions, including disinfection for 30 minutes in gluteraldehyde (Cidex). Only after an additional 45 minutes in gluteraldehyde did we eliminate the organisms.

Since we obtained the Olympus bronchoscope in 1977, the cleaning procedure has included successive aspiration of 20 percent povidone iodine scrub solution, 50 percent alcohol, and sterile water through the biopsy channel, with air drying by suctioning unfiltered ambient air. After several cultures of the sterile water aspirate were negative for pathogens, routine culturing of the bronchoscope was eliminated.

In December, 1978, the bronchoscope was used on a severely burned patient who had Serratia marcescens, Klebsiella pneumoniae, and Pseudomonas aeruginosa in her sputum and was subsequently cleared according to the procedure described above. At the time of the bronchosopic procedure, she was the only patient on the unit with Serratia sensitive to gentamicin and amikacin, all other Serratias being resistant to all antibiotics.

One week after use, sterile water was aspirated through the biopsy channel of the bronchoscope and on culture yielded heavy growth of the same organisms with the same sensitivity patterns as the patient's. The bronchoscope was recleaned and disinfected according to recently released manufacturer's instructions. These included:

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