the literature. Individual susceptibility, rather than dose-related toxicity as seen in optic neuritis, may play a role in ethambutol-induced peripheral neuropathy.

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Dressler’s Syndrome

To the Editor:

One of the important features of Chest as a resource for the cardipulmonary physician is that it is one of the few specialty journals which still publishes concise case reports. Of course, these must be considered the “salt and pepper” of medicine since they are necessarily anecdotal. The interesting report of Dressler’s syndrome by Gibbons and Vieweg is no exception (Chest 77:431-432, 1980). Although I have considerable experience in consulting on patients with recurrent pericarditis, many of whom are “steroid-hooked,” my comments on this report also can only be anecdotal since there are no appropriately designed controlled clinical trials. I make these comments because the work of the distinguished authors may influence others’ handling of comparable cases and they are only offered in a cautionary vein.

The phenomenon of what I call being “steroid-hooked” after an attack of any kind of pericarditis is uncommon, but by no means rare, and it is one of the most frustrating situations in cardiology. (It is also the reason why I have never instituted corticosteroid therapy—perhaps being lucky in this regard in the patients who happened to be in my care). I would strongly recommend—based on considerable, but as yet anecdotal experience—almost any other kind of anti-inflammatory agent, beginning with indomethacin. While corticosteroids nearly always give a satisfying “quick fix,” the occasional inability to wean the patient from them is a problem of the first magnitude.

Another problem in patients with recurrent pericarditis of any etiology, irrespective of whether they are steroid-hooked, is the resort to pericardectomy. This frequently fails to eliminate pericardial pain, probably because one can never have a complete pericardectomy owing to much of the pericardium over the atria, the necessary “tapes” of pericardium which must be left on the phrenic nerves, and the inability to quantitatively remove the epicardial layer. The patient in the report in question, however, did have another reason for operation and that was an appropriate indication for coronary bypass surgery.

This case is of additional teaching value because it illustrates the failure of corticosteroids to prevent pericardial adhesions. This has been the case in many patients who have either developed constrictive pericarditis (sometimes while still on corticosteroid therapy) or adhesions observed at operation or autopsy. Finally, the authors’ citation (ref 12) of a letter by me is of uncertain relevance. Perhaps they can clarify that point.

These comments are not offered in direct criticism of an expertly handled case expertly reported, since it is standard therapy in many institutions to use corticosteroid agents either in very painful or otherwise critical pericarditis, or where an immune mechanism may be pathogenic, as with Dressler’s syndrome. My comments are offered to supplement the authors’ astute observations.

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To the Editor:

I reviewed with Dr. Vieweg Dr. Spodick’s comments concerning the use of steroids in the treatment of pericarditis. We both strongly endorse his reluctance to utilize steroids in these situations because of the attendant problems of steroid dependence which he clearly outlines. Our patient had failed to respond to salicylates and indomethacin and was given steroids in an attempt to avoid surgery. The progressive angina, however, mounted additional indications which led to surgical treatment.

With apology, I wish to correct reference 12. The letter by Bernstein relating to tamponade complicating Dressler’s syndrome was the article referred to in the text. The corrected reference is (Bernstein A. Letter to the editor. Chest 73:439, 1978).

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Flexible Fiberoptic Bronchoscopy—an Analysis of Proficiency

To the Editor:

The recent article by Dr. Dull leaves me somewhat confused as to what constitutes a diagnostic bronchoscopy. A pathologic specimen consistent with a clinical impression does not mean a procedure was diagnostic, especially since Dr. Dull does not mention whether confirmatory evidence (autopsy, surgical) was obtained to support these diagnoses. One must also ask how a bronchoscopic diagnosis of pulmonary veno-occlusive disease or chronic aspiration is made or even if the procedure provided any useful diagnostic information in these cases.

Of the 84 procedures in which Dr. Dull felt bronchoscopy provided a diagnosis, 15 were said to be “normal endobronchial tree” or “normal (status after lobectomy for carcinoma) endobronchial tree.” If a procedure is performed to rule out an endobronchial lesion or infection such as tuberculosis, a finding of “normal endobronchial tree” is of great clinical significance but should not be considered a positive diagnosis. Many bronchoscopies are performed justifiably under conditions such as these, but the results should be analyzed

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