Dressler's Syndrome

To the Editor:

One of the important features of Chest as a resource for the cardiopulmonary 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 pericardiectomy. This frequently fails to eliminate pericardial pain, probably because one can never have a complete pericardiectomy 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.

David H. Spodick, M.D., F.C.C.P.
Professor of Medicine,
University of Massachusetts Medical School,
Director, Division of Cardiology,
St. Vincent Hospital, Worcester, MA

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...
separately from those obtained while attempting to diagnose specific lesions. Using Dr. Dull's method of analysis, one's diagnostic yield would be improved simply by bronchoscop- ing more normal people. If these 15 procedures are excluded, Dr. Dull's diagnostic yield is at best 58 percent.

Dr. Dull also compares his results with several series which are not similar. The percentages determined in these series represent the diagnostic yield in radiographically or bronchoscopically visible lesions, while Dr. Dull must have performed many procedures in which no lesion was seen or expected. While Dr. Dull's attempt to define when proficiency with the bronchoscope is reached is an admirable one, his data appear to confuse rather than clarify current views on the usefulness of the instrument.

James Pearle, M.D.
Assistant Professor of Medicine,
University of California, Los Angeles

REFERENCES


To the Editor:

I read with interest in the article by Dr. Dull that it takes approximately 100 procedures for a physician to become a proficient bronchoscopist. I would like to respond from the "teaching head" viewpoint. The FAA requires about 40 hours of flight time dual and solo, and a test, for a pilot's certificate. Some student pilots can fly a plane after five hours of instruction, others require 100 hours of flight time. The difference among students depends on skill, coordination and most importantly judgment. The goal of a bronchoscopist-teacher or student is to provide a safe procedure with the least possible discomfort to the patient and a high diagnostic yield. The overall diagnostic yield of 65 percent reported here appears lower than that of previous reports. Many factors affecting the diagnostic yield are beyond the control of the bronchoscopist. Collaboration with pathology, cytology and bacteriology laboratories is essential. The teacher of bronchoscopy has a difficult task. In university hospitals, a large number of services compete for possible patient candidates. Pulmonary medicine, thoracic surgery, ENT and the recently trained pulmonary physician practicing in the community all want to learn, teach, and perform procedures. The service with the fastest response to the call, the highest diagnostic yield and the best safety record obviously will get most referrals. Bronchoscopy with a novice bronchoscopist can be time-consuming and fairly uncomfortable for the patient and detrimental for public relations. The preselection of patients by some of the mentioned factors also makes learning difficult. The best bronchoscopy teaching can only provide an approach. To count procedures and the number of positive and negative results oversimplifies complex issues of how to learn to perform bronchoscopy, how to teach them and why and how to have them done from the patient's point of view. The paper did raise a question. I do not think it is necessary for everyone practicing pulmonary specialist to perform fiberoptic bronchoscopy procedures. Maybe we should redirect our efforts toward training fewer bronchoscopists, but spend more time establishing bronchoscopy referral centers.

Barbara Gothe, M.D.
Assistant Professor, Pulmonary Division,
Department of Medicine,
Case Western Reserve University—
University Hospitals, Cleveland

To the Editor:

I interpret three points of contention in Dr. Pearle's letter. First, he argues with my definition of a diagnostic procedure. I admit that it is purely arbitrary. However, a "pathological specimen consistent with a clinical impression" is as relevant in securing a diagnosis as many other pulmonary diagnoses. Secondly, I think the comparison of my results with other publications is valid. And last, I agree with Dr. Pearle that a bronchoscopist's impression of a normal endobronchial tree may be a false-positive result, ie, pathology may exist but was not appreciated or proven.

The letter by Dr. Pearle emphasizes two current problems with flexible fiberoptic bronchoscopy (FFB) today. One problem is the indication for this procedure. My article was not directed to this point of contention. I simply tried to address how many FFBs were required to become proficient. My interest in defining this nebulous term is altruistic. Specifically, the ATS-ACCP have introduced a formal program in fiberoptic bronchoscopy for physicians who have completed their training before 1970. The program requires two to three months to complete. Approximately 24 institutions are participating and each will accept one to two persons per year. Three criticisms are directed to this program: (1) the number of physicians accepted is very small; (2) two to three months is a long time away from a practice; and (3) what guarantees that a physician receives anything from the experience? By providing this "service," the ATS-ACCP have created themselves as the "experts" and are judging who shall be sanctioned to perform this procedure. I agree with the intent to improve the medical care in regard to FFB, but this board of "experts" should provide proof of their expertise and their product. This point is relevant to all current training programs of bronchoscopy. Thus, I merely wanted to analyze one aspect of proficiency. I am unaware of other studies which have attempted to clarify this point.

Although my article has faults, it advances the notion of trying to objectively define what we are doing in the art of pulmonary medicine.

W. L. Dull, M.D.
Institut National de la Sante et de la Recherche Medicale, Nancy, France

REFERENCES

1 Gross NJ. What is this thing called love? Or, defining Thuma. Am Rev Respir Dis 1980; 121:203-204
2 Statement of Committee on Sarcoidosis, Division of Medical Sciences, National Research Council, 1956