Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Specific permission to publish should be cited in a covering letter or appended as a postscript.

Malpositioned Nasogastric Tube Causing Pneumothorax and Bronchopleural Fistula

To the Editor:

Drs. Torrington and Bowman (Chest 1981; 79: 240-42), report an interesting case of a hydrothorax and empyema resulting from a bronchially-placed nasogastric tube. We would like to describe a similar case.

Case Report

A 57-year-old woman was admitted to the neurosurgical intensive care unit with depressed mental status, resulting from an occipital lobe glioblastoma multiforme. The patient was uncooperative and repeatedly pulled out the nasogastric tube. Each time the tube was replaced, the position was checked by insufflation of air and auscultation over the left upper abdominal quadrant. Review of the morning routine chest roentgenogram revealed the nasogastric tube passing down the left lower lobe bronchus to the extreme periphery of the lung (Fig 1) and a pleural effusion, which had been present and unchanged for a few days.

The nasogastric tube had been placed a few hours earlier and was not connected to suction and no enteral nutrition had been introduced. The tube was removed, but the patient developed progressive respiratory distress with labored breathing and deteriorating oxygenation and ventilation. Repeat chest roentgenogram showed a hydropneumothorax. A chest tube was inserted which drained air and 600 ml of serosanguineous fluid. The problem was not resolved and the patient developed a bronchopleural fistula.

It is tempting to believe that a blindly placed malpositioned nasogastric tube in the left side of the lower lobe would be likely to be mistaken for correct placement since the air injected to confirm the position of the tube would yield sounds in the upper part of the left upper quadrant. We believe that the peripherally placed nasogastric tube was pushed through the parietal pleural and the insufflation air produced a pneumothorax and a bronchopleural fistula. Malpositioned nasogastric tubes in the lung have been described even in patients with cuffed endotracheal tubes and produce problems of persistent hypoxemia, atelectasis and loss of delivered tidal volume particularly when attached to suction.

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Reference


Alcohol-induced Bronchospasm

To the Editor:

I read with interest the report on alcohol-induced bronchospasm in an asthmatic patient by Henry Gong, Jr., et al in the August, 1981 issue of Chest. I would like to ask if they entered the causative agent as being an additive to the alcohol. For example, Stevenson and Simon recently reported several cases of sodium metabisulfite hypersensitivity in several asthmatic patients who ingested red wine. A variety of sulfiting agents, including sulfur dioxide and inorganic sulfites, have been employed in food processing. The sodium metabisulfite hypersensitivity was confirmed by oral provocation testing.

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Reference


To the Editor:

Although sulfiting agents are widely used in the food industry, we do not believe that ingested metabisulfites were the asthma-inducing agent in our subject, since he denied allergies or adverse reactions to foods or restaurant meals (excluding alcoholic beverages). Although the bronchoconstriction developed with ingested beer could be due either to alcohol or to various additives, the consistent bronchoconstrictor effects of alcohol (95% ethanol) administered by different routes strongly suggested that this individual was highly sensitive to alcohol alone. We are not aware of a metabolic mechanism that converts alcohol to sulfites or sulfur dioxide in the body.

The results reported by Stevenson and Simon, as well as by us, support the concept that some asthmatic patients may be exquisitely sensitive to ingestion of different substances. Future case reports with supportive challenge studies and

Figure 1. Chest roentgenogram showing the nasogastric tube in the periphery of the left lung.

CHEST, 81: 3, MARCH, 1982

Communications to the Editor 389