ular responses could be obtained. She was discharged on these medications and is doing well four months later.

Aerobic dancing which becomes anaerobic is hazardous to your health.

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Wire Basket Removal of a Tack Via Flexible Fiberoptic Bronchoscopy

To the Editor:

In artificial and animal lung models, a wire basket inserted through the channel of a flexible fiberoptic bronchoscope successfully retrieved only bulky objects but failed to retain thin items.\(^1\) We report the successful removal of a tack from the bronchial tree of a 73-year-old patient using a Fogarty balloon and wire basket passed through the aspiration channel of a flexible fiberoptic bronchoscope.

CASE REPORT

A 73-year-old man was admitted for treatment of congestive heart failure. He was a chronic alcoholic, had worked as a painter and wall paper hanger, and had frequently held tacks between his teeth and drunk alcohol while working. Physical examination showed evidence of congestive heart failure. A chest x-ray film (Fig 1) revealed consolidation and a tact in the right middle lobe, and a small right pleural effusion. The pleural fluid was a transudate and thought to be secondary to congestive heart failure. After correction of the heart failure, flexible fiberoptic bronchoscopy was performed through the oral route. The distal tip of a tack was visualized in a subsegment of the right middle lobe bronchus. This area was definitely unreachable by rigid bronchoscopy. The bronchus was 50 percent occluded by the tack and surrounding bronchial edema; purulent secretions were seen distally. An initial attempt to remove the object with an Olympus biopsy forcep was unsuccessful. On repeat bronchoscopy, a Fogarty balloon was used to dislodge the 12 mm x 4 mm tack into the right middle lobe bronchus and it was then captured and removed with a wire basket (Olympus FG-17 K 51637).

DISCUSSION

Different extraction tools may be inserted through the biopsy channel of a flexible fiberoptic bronroscope.\(^1\) The Olympus forceps failed to grasp the tack because of its small jaws. A crocodile forceps might have been successful. We removed the tack by first dislodging it into a larger airway with a Fogarty balloon and then captured it with a wire basket. The interesting feature of this case is that the wire basket was successful in retaining this thin item.

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REFERENCE


Acute Thrombophlebitis due to IV Use of Amiodarone

To the Editor:

Amiodarone (2-buty1-3-[3,5-diido-4-b-dietylaminioethoxy-benzoyl]-benzofuran) is an effective and extensively used drug (mostly in Europe and South America) for the treatment of angina pectoris and arrhythmias, usually by mouth. Recently, the drug has been introduced for IV use for therapy of severe or intractable arrhythmias. The drug is known to produce pharmacodynamic effects such as bradycardia, prolongation of the Q-T interval and changes of the T wave. In addition, it can create side-effects such as corneal pigmentation, melanodermitis and photosensitivity with erythema and itching, which can be promoted by sunlight.

The purpose of this communication is to focus attention on an additional side-effect which consists of severe local reaction at the site of the IV injection with severe pain, thrombophlebitis, inflammation and swelling, extending beyond the site of injection. The following three patients in whom the drug was used IV for the first time, illustrate the situation.

Case 1

A 62-year-old man entered the CCU due to a recent acute myocardial infarction with attacks of severe supraventricular tachycardias (220/min) resistant to various drugs and D-C shocks. Amiodarone was used IV with a bolus injection of 300 mg followed by supplementary infusion of 600 mg by drip. The tachycardia responded promptly, but within a few hours the patient complained of

Figure 1. Chest x-ray film showing pneumonia and a tack in the right middle lobe.
severe pain at the site of infusion; redness and swelling of the arm appeared with the full picture of acute thrombosebitis which extended towards the axilla. Change of the infusion to the opposite arm created the same reaction, but early withdrawal resulted in a less severe reaction. The signs and symptoms subsided within a week.

**Case 2**

A 52-year-old man entered the CCU with an acute myocardial infarction and intractable supraventricular tachycardia (250/min) resistant to all attempts at conversion with drugs and D-C shock. Amiodarone was given IV as in case 1 and the tachycardia subsided, but soon he developed severe local pain with redness and swelling; acute thrombosebitis extended up to the axilla. The infusion was interrupted and the local reaction subsided after ten days.

**Case 3**

A 45-year-old man suffering from myocardiopathy entered the hospital with a severe attack of supraventricular tachycardia (280/min) and collapse. D-C shocks were only transiently effective in restoring rhythm and blood pressure. All other drugs were either ineffective or created dangerous bradyarrhythmias. Amiodarone IV in the same doses as previously was very effective in restoring rhythm, but soon created severe local reaction with thrombosebitis, pain, redness and swelling of the arm which necessitated interruption of therapy.

From our experience, amiodarone given IV in doses of 7.5-10 mg/kg is a very valuable antiarrhythmic drug, but with a high frequency of severe local reaction consisting of pain, redness, swelling and acute thrombosebitis extended beyond the site of infusion and which may prohibit its continuous IV use. It is possible and it would be advisable to use a central venous catheter in order to decrease or avoid the severe local reactions.

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**New Insights into the Airways**

**To the Editor:**

Dr. Rucker (Chest 1981; 80:121) has emphasized the value of smaller flexible bronchoscopes in neonates and quite properly noted some of their limitations. It is indeed encouraging to see the progress made in the development of the smaller instruments and we also are impressed with their usefulness in selected pediatric applications. There are several points in this editorial which we feel deserve comment.

Fortunately, most, if not all, of the limitations of the flexible instruments can be overcome by the skillful application of modern fiber-illuminated endoscopes and telescopes. Unfortunately, there seems to be an increasing number of practitioners whose training and interests are limited to the flexible instrument. In perhaps no other field of medicine does a complete and up-to-date instrumentarium applied by one of broad training and mature judgment more often determine the success or failure of a physician's diagnostic effort. Without this capability, our pediatric patients especially are ill served.

We have used flexible instruments extensively to evaluate stridor and other problems of the pediatric airway. These instruments are not, however, "almost completely replacing direct laryngoscopic examination" in our practice. Their value is not in question, but we have repeatedly demonstrated the necessity for direct laryngoscopy in order to establish the correct diagnosis, especially in the posterior larynx and subglottis. The posterior commissure web and arytenoid fixation are frequently misdiagnosed as vocal cord paralysis unless the tissues are displaced by direct techniques. The evaluation of subglottic disease is also frequently inadequate if one must limit oneself to the use of flexible instruments.

We are among the most enthusiastic proponents of flexible instruments when they allow us to do a better job. Let us not, however, dispose of instruments of proven value because we now have a new one whose role is still being ascertained. Our real need is for broadly-trained physicians who understand how and when to apply the most suitable instrument regardless of its configuration.

**Bernard R. Marsh, M.D.,
Associate Professor of Laryngology and Otology, The Johns Hopkins University School of Medicine, Baltimore**

**To the Editor:**

There are certainly points in Dr. Marsh's letter that are well taken and I wish to clarify some of these points.

In the evaluation of upper airway problems, i.e., above the vocal cords, we feel that the transnasal fiberoptic approach allows a better representation of the physiologic functioning of these glottic structures as the degree of distortion and invasiveness is much less. Specifically, this is in reference of a lack of need for either general anesthesia or local anesthesia directly upon the larynx or the posterior pharynx. It is not necessary to keep the tongue forward or to keep the mouth open, as we are aware.

It is not implied that the small fiberoptic instruments can replace the direct laryngoscope and/or the direct bronchoscope in situations where the fiberoptic bronchoscope is limited by its physical characteristics. In my editorial I generally agreed with Dr. Marsh's point about subglottic disease being best diagnosed in children by the straight bronchoscope.

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