Drinking and Passive Smoking

To the Editor:

I read with great interest the special report, "The health risks of passive smoking" (Chest 1983; 84:90-5). The nonsmokers' rights movements have little power in Japan at present. In many cases, Japanese smokers themselves should be chastised for their smoking habits. They smoke in public, on trains, and even in the office at work. The harmful effects of passive smoking on nonsmokers do not appear to concern them. Coffee and tea breaks are times for relaxation and refreshment. Smokers should refrain from smoking at these times unless a "tobacco break" is specified. No one drinks alcoholic beverages in the office at work. Why should smokers not abstain from smoking?

Speaking of alcohol, some investigations have suggested that functional pulmonary impairment was present in alcoholics after correcting for cigarette smoking. More recently, Lebowitz indicated that alcohol consumption affected respiratory symptoms and lung function even when controlling for smoking habits. But in none of these studies were the effects of passive smoking taken into account. Moderate-to-heavy drinkers tend to stay longer in bars, pubs, or saloons, and chronic effects of passive smoking ("unclean indoor air") on respiratory symptoms and pulmonary function should be considered.

An independent effect of passive smoking on healthy persons might be a menace to nonsmoking social drinkers. I hope that nonsmoking bars, as well as nonsmoking restaurants and hotels such as those in the United States and Canada, will increase in Japan in the near future.

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REFERENCES


Use of Fogarty Catheters for Removal of Tracheobronchial Foreign Bodies

To the Editor:

In the April, 1982 issue of Chest (81:524) Wiesel et al have described the use of the Fogarty arterial embolectomy catheter for removing a tracheal foreign body. We too have been using the same technique for the last few years and have found it very useful in extricating smooth-surfaced beads with central lumen (5 in all). We have always found visual localization of the bead (with the lumen outlined) on the chest x-ray film (Fig 1) useful in planning the use of a Fogarty catheter electively. This saves anesthesia time and possible injury to the mucosa by repeated use of forceps. We have also used the same technique in removing other foreign bodies with a lumen (like metallic bolts) which are impacted in the bronchus.

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Post-bronchoscopy Palatine Paresthesia

To the Editor:

Fiberoptic bronchoscopy is a common clinical procedure. Recently, we have encountered a minor complication that has not previously been reported. The subject, a healthy 30-year-old medical student (RDM), underwent transnasal fiberoptic bronchoscopy on two separate occasions for research purposes. No premedication was given and anesthesia was obtained with 4 percent topical intranasal cocaine and 4 percent lidocaine aerosol to the oropharynx and larynx. A flexible 5.9 mm diameter fiberoptic bronchoscope was passed through the right nostril on each occasion. Each bronchoscopic procedure lasted approximately 15 minutes and was performed without apparent complication. Shortly after the first procedure, the subject noted numbness and tingling in a small area of gum and hard palate midline behind the superior incisors. This paresthesia lasted 48 hours and resolved completely. The second procedure, performed ten weeks later, was followed by a similar paresthesia which lasted ten days.

These symptoms and their distribution and time course are consistent with a neuropraxia of the nasopalatine nerve. This nerve courses along the nasal septum, passes through the incisive canal, and innervates a small region of mucoa just behind the incisor teeth. Anesthesia in this distribution can be obtained by blocking the nasopalatine nerve. It is likely that the neuropraxia in this case was caused by compression from the bronchoscope. Although the subject had a history of a rhinoseptoplasty, careful examination of the nares showed no abnormality. Review of the literature has not revealed any report of this complication following fiberoptic bronchoscopy, nasotracheal or nasogastric intubation. Still, this complication may be more frequent than recognized, as the superficial location of the nerve facilitates compression by foreign objects, but the area innervated is quite small. Since the symptoms resolved spontaneously each time, reassurance seems to be the appropriate form of therapy.


FIGURE 1. Radiograph of the chest showing a bead in the right main bronchus. The central lumen is clearly outlined.