would have been interesting to note the differences between these two groups. Second, visual monitoring as opposed to continuous electrocardiographic (ECG) monitoring was used. We have previously demonstrated that one can easily underestimate the actual incidence of arrhythmias, including serious ones, if continuous monitoring is not used. Several studies have demonstrated a higher incidence of ventricular arrhythmias using continuous electrocardiographic monitoring. Elliott showed that cardiac complications were frequent (not infrequent as stated by the authors) with a deviation from baseline rhythm in 78 percent, premature ventricular contractions in 46 percent and ventricular tachycardia in 33 percent of 116 critically ill patients. We have demonstrated a 53 percent incidence of advanced ventricular arrhythmias using continuous ECG monitoring in 119 critically ill patients with shock, complicated myocardial infarction or ischemia and respiratory failure. Therefore, physicians treating seriously ill patients should not become complacent with this reported low incidence of ventricular ectopy, as continuous monitoring was not used and many of the patients were not critically ill. Ventricular arrhythmias remain a serious and frequent complication of catheterization. Interestingly, we have recently demonstrated that prophylactic lidocaine can decrease the incidence of advanced ventricular arrhythmias in critically ill patients undergoing catheterization requiring less than 20 minutes.

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Cavitation in Acute Histoplasmosis

To the Editor:

We agree with Dr. Sprung and his colleagues that the incidence of ventricular arrhythmias observed during passage of a pulmonary artery catheter is dependent upon the type of monitoring employed, as well as upon the severity of the patient's underlying disease. A continuously recorded electrocardiogram documents more catheter-induced ventricular arrhythmias than does simple visual inspection via an oscilloscope.

The hemodynamic consequences of ventricular ectopy seem to depend primarily upon the presence or absence of acute cardiac or pulmonary disease. Catheter-induced ventricular arrhythmias in patients undergoing catheterization prior to cardiac surgery (a “good risk” group without acute disease) cause minimal, if any, hemodynamic compromise and are unlikely to progress to sustained ventricular tachycardia or fibrillation. In our institution, in over 5,000 such catheterizations, we have never observed ventricular fibrillation. The absence of acute disease or ischemia may explain the inability of lidocaine, administered immediately prior to catheterization, to control or abolish ventricular arrhythmias in this group of patients. Lidocaine may be more efficacious in the patient with acute ischemia or hypoxemia by suppressing arrhythmias due to pre-existing disease which may be exaggerated during catheter placement.

The reports of Dr. Sprung and his colleagues3 describe the difficulties that may be encountered when catheterizing acutely ill patients. The occasional need for pharmacologic, electrical or mechanical therapy for ventricular irritability emphasizes that such treatment aids must always be immediately available during placement of a pulmonary artery catheter. In addition, the operator must pay continuous attention to the electrocardiogram and to the clinical condition of the patient and not become totally involved with catheter insertion to the exclusion of all else.

The risk of death secondary to catheter placement is still minute. The deaths reported by Dr. Sprung4 occurred in patients who died from ventricular fibrillation but who were already in cardiogenic shock with little chance of survival.

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To the Editor:

Bennish et al in their case report, "Cavitation in Acute Histoplas-

mosis" (Chest 1983; 84:496-97) indicate that they "... could not find well documented report of ... " cavity formation in acute histoplasmosis.

Two large outbreaks of histoplasmosis occurred in Indianapolis in 1978-79 and 1980-81 affecting about 150,000 people. Cavitary histo-

plasmosis occurred in 8 percent of these cases. Upper lobe infiltrates with thin or thick walled cavities or cystic changes were common. Air fluid levels also occurred. One third of the patients improved without treatment. Amphoteracin B and ketoconazole were useful in cavitary histoplasmosis.1,2

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