We disagree with the statement that the presence of a pneumothorax precludes a second attempt at biopsy. In fact, the presence of a pneumothorax following the initial procedure often renders a poorly defined lesion much more visible at fluoroscopy.

An additional point not raised by the authors and which we feel is of value following a percutaneous lung biopsy is to place the hemithorax biopsied in a dependent position. This reduces both alveolar size, as well as the alveolar-to-pleural pressure gradient in the region surrounding a pneumothorax. This should decrease the rate of pneumothorax formation and permit sealing of the puncture site. We attempt to maintain our post-biopsy patients in this position as far as is possible for a period of approximately 12 hours following the procedure.

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REFERENCES


To the Editor:

I cannot see how Figure 1 in Dr. Krongrad's article (Chest 1984; 85:107-13) illustrates a patient who "may eventually require treatment with a cardiac pacemaker" as "the cardiac rhythm decreases." There is nothing in the four strips shown to presage bradyarrhythmic problems: the junctional rhythm during sleep occurs frequently in normal young individuals; while the "marked sinus arrhythmia" is a simple misinterpretation of what appear to be junctional premature complexes.

In the context shown, I would only contemplate pacemaker therapy for the more likely possibility of intractable supraventricular tachycardia.

George Nikolic, M.D., Director, Intensive Care Unit, Woden Valley Hospital, Woden, Australia

REFERENCE


To the Editor:

Dr. Nikolic objects to the suggestion that patients with transposition of the great arteries who manifest junctional rhythms after the Mustard operation may eventually require pacemaker therapy. The objection is based on the premise that "junctional rhythm during sleep occurs frequently in normal young individuals." I would agree with Dr. Nikolic that junctional rhythms indeed occur frequently in young individuals, but I would like to alert physicians who take care of young patients following a Mustard operation that in the context of transposition of the great arteries such junctional rhythms are most often due to sinus node injury rather than a normal phenomenon. Indeed, the tracing given in our Figure 1 is from a patient who eventually required pacemaker therapy when ambulatory electrocardiography revealed a heart rate of 14-19/min over extended periods of time during his adolescent years.

In general, our experience is that patients who manifest a sick sinus syndrome following a Mustard operation most often require pacemaker therapy for bradyarrhythmias rather than therapy for the bradycardia-tachycardia syndrome.

I believe Dr. Nikolic's letter is important because it re-emphasizes the issue of sick sinus syndrome in patients following the Mustard operation and allows to indicate on its very early manifestations.

Ehud Krongrad, M.D., Columbia Presbyterian Medical Center, New York City