Wire Basket Removal of a Large Endobronchial Foreign Body

To the Editor:

Different extraction tools (forceps, claw, balloon catheter and wire basket) used with fiberoptic bronchoscopy for the removal of aspirated foreign bodies have been evaluated in artificial and animal (dog) lung models, as well as in human cases in the past. In the following case report, the successful removal of a large foreign body is described using a wire stone basket passed through the biopsy channel of a fiberoptic bronchoscope.

CASE REPORT

A 69-year-old man with a permanent tracheostomy presented to the emergency room after accidentally dropping a pair of forceps through his tracheal stoma. Eleven years previously he underwent a total laryngectomy and left radical neck dissection for squamous cell carcinoma of the larynx. He was without dyspnea, cough, or chest pain. On physical examination, breath sounds were symmetrical and no wheezes were heard. A chest x-ray film (Fig 1) revealed a pair of tweezer forceps, approximately 9 cm in length located in the distal trachea, right main and right lower lobe bronchus. It was felt after otolaryngologic evaluation that the patient’s prior surgery precluded use of the rigid bronchoscope. Flexible fiberoptic bronchoscopic examination revealed the forceps tips in the proximal right main bronchus. Attempts to remove the tweezers with alligator forceps (Olympus) were unsuccessful. They were then easily captured and removed with a Dormia stone basket (Fig 2).

DISCUSSION

Reports describing the use of the basket forceps with bronchoscopy in the removal of aspirated foreign bodies from the tracheobronchial tree have been few. In experimental lung models, Zavala and Rhodes concluded that wire baskets were most effective in recovering bulky and organic objects (peanuts, beans, chicken...).
Contralateral Chylothorax: One More Complication of Subclavian Venous Puncture

To the Editor:

In June 1983, Ciment et al reported two cases of contralateral effusions secondary to subclavian venous catheters (Chest 1983; 83:926-27). We recently observed right chylothorax in a 75-year-old man 15 days after problematic insertion of a definitive endovenous pacemaker into the left subclavian vein. Other potential causes of chylothorax, especially neoplasm, were excluded. The chylothorax resolved spontaneously and did not recur.

To our knowledge, this is the first report of a chylothorax secondary to endovenous pacemaker insertion (Acta Clin Belgica, in press). However, subclavian vein puncture has already been mentioned by Marsac as a possible cause of chylothorax.1 The mechanism is similar to that described by Ciment et al. Mediastinal leakage of chyle occurs first, and the pleural effusion (homolateral or contralateral) may appear as late as two weeks after the puncture, as in our case. As central venous catheters are used more and more, it is important to be aware of potential complications, either classic or rare. Late-appearing contralateral effusion or chylothorax may represent a diagnostic challenge. As Ciment et al point out, the more frequent use of right internal jugular vein for central catheters may significantly reduce complications, and subclavian venous catheters should be reserved for emergencies or profoundly hypovolemic patients.2 Pneumothoraces and hydrothoraces are less frequent with the internal jugular vein approach and chylothorax has not been reported using this insertion route.3

REFERENCES

Early Diastolic Sound

To the Editor:

Humen and colleagues (Chest 1984; 86:90-4) have identified a potentially valuable association between a proposed septal heart sound and abrupt leftward motion of the interventricular septum during ventricular relaxation in patients with diastolic volume overload of the right ventricle, particularly after RV disconnection for arhythmogenic dysplasia. In three of four cases the "septal sound" might equally be an early S3 and in the fourth (patient 4) it does appear to be an extra sound between S1 and S2. In conditions like constrictive pericarditis, for example, the abnormal early diastolic sound (an S3 variant) occurs quite early, often at 0.11 to 0.12 second and, in fact, was reported by Hancock at 0.06 second after S1 in one case.

It is easy to see why the authors had some difficulty in aligning the new sound with the apexcardiogram, if the sound is generated primarily by right ventricular events; the apexcardiogram is, after all, a left heart curve. Its registration in the reported patients shows some influence from right ventricular events; indeed, the inverted systolic phase is typical of constrictive pericarditis. I wonder if the authors would care to comment on the fact that with a nearly nonfunctional dilated right ventricle in three patients, we could be dealing with a situation analogous to pericardial constriction. Similarly, in RV infarction, the hemodynamics resemble those of constrictive pericarditis—mainly ascribable to the influence of the normal pericardium on ventricular interaction. Thus, a dilated right ventricle—at least in the short-run after disconnection—within a non-yielding pericardium, will act to tighten the pericardium and therefore relatively constrict the heart. Of course, the "septal sound" does coincide with leftward septal motion, not seen in constriction. Would the authors comment on whether this sound could be a RVS3 earlier than any LVs3?4

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