were found in PLM tissue,\textsuperscript{15,16} this has never been demonstrated, to our knowledge, in tuberculous

There are two previously published reports related to the use of tamoxifen in PLM.\textsuperscript{16,17} Both women had severe respiratory insufficiency and the drug was ineffective in arresting the course of the disease, but tamoxifen was given at a very late stage. One of them had cor pulmonale and the other, who had high level of estrogen receptor, was seriously ill and on mechanical ventilation at the start of therapy.

The administration of pharmacologic doses of tamoxifen during 24 months and the use of tetracycline pleurodesis was associated with improvement of some clinical and laboratory manifestations and stabilization of the respiratory picture in our patient. Both measures seem to be effective therapies for this rare pulmonary disease and the response to tamoxifen is probably related to the presence of an estrogen receptor.

Finding an estrogen receptor in this patient is new evidence that supports the association between PLM and tuberculous sclerosis.

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References


Massive Hemoptysis Associated with Foreign Body Removal*

J. Richard Rees, M.D., F.C.C.P.

Exsanguinating hemoptysis accompanied removal of an endobronchial foreign body in a 12-year-old child. Preparations to treat this complication should be made prior to removal of any foreign body of prolonged sojourn in the tracheobronchial tree.

The most common serious complication accompanying bronchoscopy for removal of foreign bodies in the tracheobronchial tree is cardiac arrest due to asphyxia.\textsuperscript{1,2} From a review of the literature, massive hemorrhage accompanying bronchoscopy for foreign body removal is an unusual complication.

Case Report

A 12-year-old white girl presented to the hospital with fever, chest pain and hemoptysis. An admitting chest x-ray film (Fig 1) demonstrated an infiltrate in the right lower lobe and a foreign body in the right main stem bronchus. The patient gave a vague history of having swallowed a bullet seven years previously. The foreign body, an intact .22 short caliber cartridge casing, was removed easily through a rigid scope. Immediately after removal of the foreign body, massive hemorrhage into the right main stem bronchus ensued, which was then tamponaded with cotton and gauze. The patient was placed in the left lateral decubitus position and an emergency right thoracotomy was performed. The patient then sustained cardiopulmonary arrest. The right mainstem bronchus was opened proximal to the tamponade and a considerable amount of old blood was aspirated from the left main stem bronchus as successful cardiac massage was carried out.

Postoperatively, the patient developed adult respiratory distress syndrome plus a bronchopleural fistula requiring prolonged mechanical ventilation and the construction of an Elsasser flap. She subsequently recovered, underwent plastic repair of the chest wall with two artificial ribs and has done well.

Discussion

In their monumental work on foreign bodies in air and food passages, Jackson and Jackson described 343 patients with prolonged sojourn of foreign bodies in the air passages.\textsuperscript{1} These same authors were able to remove most of these foreign bodies transbronchoscopically and, in most instances, noted resolution of the underlying inflammatory process in the

*From the University of Utah College of Medicine, Salt Lake City.
†Assistant Clinical Professor of Surgery.
Reprint requests: Dr. Rees, 425 East 5350 South, Ogden, Utah 84405
lungs. No instance of massive hemorrhage accompanying bronchoscopy was noted.

Linton\textsuperscript{4} reported the results of treating longstanding foreign bodies in 16 patients. In six of these patients, the foreign body could be removed through the bronchoscope. One of the six required lobectomy because of abscess. One of the 16 patients required bronchotomy for removal of the foreign body, and six required pulmonary resection. No instance of massive hemorrhage at the time of bronchoscopy was recorded.

Foreign body bronchietasis may require lung resection following prolonged sojourn of foreign bodies in the tracheobronchial tree. Cooley et al\textsuperscript{1} reported on 14 such patients at the Mayo Clinic.

As noted by Bogedain,\textsuperscript{4} foreign bodies in the pulmonary parenchyma may migrate to an intrabronchial position and be removed transbronchoscopically many years later.

In a review of the over 2,500 documented cases,\textsuperscript{1,2,3,4,6,8,11} the author was unable to find another instance of massive hemorrhage accompanying removal of an intrabronchial foreign body, whether performed acutely or after prolonged sojourn.

CONCLUSION

The tracheobronchial endoscopist should have this possible complication in mind and manage to meet it by: 1) tamponading the bronchial system on the side that is bleeding; 2) carrying out endotracheal intubation; 3) suctioning the contralateral side for blood that has spilled over from the hemorrhage; and 4) and performing immediate thoracotomy on the affected side.

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Dissecting Aneurysm of the Ascending Aorta with Aorto-caval Fistula\textsuperscript{a}

Fiberoptic Oximetric Findings and Surgical Management

J. B. Martinot, M.D.;\textsuperscript{†} O. Pedemonte, M.D.;\textsuperscript{†} P. L. Baele, M.D.;\textsuperscript{†} J. Dautrebande, M.D.;\textsuperscript{§} P. Jaumín, M.D.;\textsuperscript{‡} and M. Goenen, M.D.;\textsuperscript{†}

\textsuperscript{a}From the Cliniques Universitaires Saint-Luc, Brussels, Belgium.
\textsuperscript{†}Intensive Care Unit.
\textsuperscript{‡}Department of Anesthesiology.
\textsuperscript{§}Department of Radiology.
\textsuperscript{‡}Department of Thoracic and Cardiovascular Surgery.

Reprint requests: Dr. Goenen, Service Soins Intensifs, Cliniques Universitaires St. Luc, 10, Av Hippocrate, 1200 Brussels, Belgium.

Dissecting Aneurysm of Ascending Aorta (Martinot et al)