To the Editor:

Despite the well-accepted assumption that tricuspid insufficiency develops secondary to cor pulmonale, this fact has not been well substantiated in the literature. Indeed, in Circulation (31:1965) Sherman et al demonstrated the rarity of this lesion in the presence of normal sinus rhythm, thus the purpose of the article.

As to the objection of the use of the term "ventricularization," I admit, in retrospect, that perhaps it was not the most appropriate. The catheterization data reflect an element of right ventricular failure, but I feel that the right atrial pressure curve reflects this fact as well as demonstrates the picture associated with tricuspid insufficiency.

As stressed in my article, one cannot make a diagnosis of tricuspid insufficiency on one facet of the case alone. The full gamut of clinical findings and laboratory correlation is necessary. Certainly, in the case presented there is no doubt that the sum total of clinical and laboratory data more than amply fulfill the criteria for a diagnosis of tricuspid insufficiency secondary to cor pulmonale.

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PROVOCATIVE WORDS ABOUT
"GUILT-RIDDEN PHYSICIANS"

To the Editor:

Your series of articles in the April, 1970 issue on polyethylene catheters in the pulmonary arterial tree prompts this communication. In careful analysis of all the cases presented, none of the patients was symptomatic nor had any complication from the presence of the catheters in the pulmonary arterial tree or the cardiac chambers. The attempts at retrieving the broken catheters were more traumatic and more dangerous than leaving the harmless catheter behind.

We have followed a policy of explaining to the patient the presence of the broken catheter in the vascular system and that it is not harmful; in the seven or eight patients we have seen when called in consultation, none has had any sequelae from the presence of such a catheter in the right heart or pulmonary tree. After all, we are constantly placing catheters of much larger size (transvenous pacemaker electrodes) for permanent position in the right heart chamber and superior vena cava with no serious complications. Thousands of transvenous pacemaker catheters have been placed safely. The concern over a tiny polyethylene, non-reactive piece of plastic is overdone. The body rapidly walls off and isolates such a needle so that it will be of no future harm either.

Cannulas are going to break off from time to time; that is why we use only "needle in catheter" type and not the "catheter in needle" type. However, the danger is not in the catheter embolizing to the lungs or heart, but in a guilt-ridden overzealous physician making multiple incisions up the arm attempting to retrieve his catheter, or even worse, talking some hapless thoracic surgeon into operating upon the patient to get his worthless cannula back.

The reason hundreds of cannula emboli have not been reported is the fear of malpractice litigation on the part of physicians. The breaking off of a catheter is not malpractice, but the vigorous pursuit of it into the deep recesses of the body certainly approaches bad medicine.

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