We do agree that transbronchial lung biopsies without fluoroscopic study can be safely and selectively performed in both sarcoidosis and other diffuse infiltrative lung diseases.

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Breakage of the Wire Cytology Brush During Fiberoptic Bronchoscopy

To the Editor:

We read with interest the letter by Doctor Sanders (Chest 1983;83:335-36) regarding separation of the wire cytology brush from its attachment to the wire guide during bronchoscopy, and the letters by Doctors Malik and Behera (Chest 1984;85:837-38 and Chest 1985;86:147), Masa-Jimenez et al, and Weissberg (Chest 1985;86:156) regarding breakage of alligator forceps during bronchoscopy.

We have experienced breakage of the wire cytology brush (Olympus BC-10C) while performing fiberoptic bronchoscopy (Olympus BF-ITR) in a 58-year-old woman with pulmonary density which proved to be infectious. The 1.8 cm tip of the brush/wire was lost in the parenchyma of the right medial lobe beyond the view of the bronchoscopist.

The foreign body presented itself on X-ray film (Fig 1). Under fluoroscopic guidance, it was removed from the medial segmental bronchus in the right medial lobe with a forceps (FB-19C-S) through a fiberoptic bronchoscope.

We have been able to sort out the exact reason for the breakage.

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Junctional Ectopic Tachycardia in Adults Role of Triggered Activity

To the Editor:

Rapid junctional ectopic tachycardia has been described in infancy. Typical features include a rapid, irregular heart rate and atrioventricular dissociation. In a recent report, Ruder et al1 describe five adults with junctional ectopic tachycardia, reporting detailed analysis of the ECGs, electrophysiologic studies and response to therapy. The authors affirm that this arrhythmia has not been previously described in adults and that, in their experience, it appears to be not responsive to verapamil therapy. Arrhythmia responded somewhat to β-blocker therapy, suggesting that, in these cases, abnormal automaticity due to sympathetic overactivity might be the mechanism of the arrhythmia. Conversely, our previous experience,2 while confirming the benign course of arrhythmia in adults, provides indirect evidence that, in some patients, triggered activity may be the tachycardia mechanism. Indeed, therapy with intravenous verapamil (8 mg) promptly slowed the junctional focus rate so that capture of ventricles by sinus impulses occurred. Irregularity of junctional pacemaker rate in association with atrioventricular dissociation suggested the diagnosis of junctional ectopic tachycardia. In addition, the acceleration of junctional focus from 120 to 150/min in all probability induced a Wenckebach block from the ectopic focus, as suggested by the cycle length alternation phenomenon. The cycle length alternation, in our case, was not due to double nodal pathway because the tachycardia rate was irregular even during the cycle length alternation phenomenon. Finally, the verapamil therapy did not stop the arrhythmia but slowed the junctional pacemaker rate so that capture of ventricles by sinus impulses occurred.

The patient had been asymptomatic before the arrhythmia occurrence and in all probability tachycardia was related to catheter manipulations. Although normal junctional automaticity in human subjects seems to be insensitive to treatment with verapamil,3,4 it is not improbable that in some patients these interventions may trigger

Figure 1. Fragment of wire cytology brush shown on X-ray film and after removal
abnormal automaticity and so may create conditions in which the slow-inward current is operative. Thus, junctional ectopic tachycardia appears to be related to abnormal automaticity that in some cases may be catecholamine sensitive, in others calcium channel-dependent.

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REFERENCES


Gorham's Disease of the Clavicle with Bilateral Pleural Effusions

Eight Years Later

To the Editor:

A case of Gorham's disease (disappearing bone disease) of the clavicle with bilateral pleural effusions was described by us in Chest. This was the second published survivor having this bone disease with pleural effusions. New bone is now evident at the site of the excision. To the best of our knowledge, new bone formation has not been reported in previous cases of Gorham's disease. It seems to us worthwhile to comment briefly on the outcome.

CASE REPORT

A 36-year-old woman presented with bilateral sanguinous pleural effusions and a lytic process of the right clavicle. A diagnosis of Gorham's disease of the clavicle was based on the histologic findings of angiomatosis of the bone and no evidence of malignancy on pleural biopsy and cytology of the pleural fluid. Talc was installed into the pleural spaces, with subsequent resolution of the effusions.

Now, eight years later, the patient is feeling well. The pleural spaces appear normal. In the region of the excised clavicle, new bone formation is seen (Fig 1), first noted about five years after the operation. The new bone is slightly deformed. Clinically, some pain is felt on moving the right arm, probably due to the bone's instability.

DISCUSSION

This case again proves that Gorham's disease is a benign process that, in spite of its benignity, may cause bloody pleural effusion. Local excision of the affected bone and obliteration of the pleural cavities (eg, by installing talcum) seem to be appropriate measures for the resolution of the process.

New bone formation is possible, provided that enough periostium is left over. The new bone seems not to be affected again by the lytic process.

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REFERENCES


Isoenzyme Pattern of Enolase and Creatine Kinase in Small Cell Lung Cancer Patients

To the Editor:

Clinical and biologic peculiarities of small cell lung carcinoma (SCLC) have been published. Several authors have emphasized a potential interest in neurone-specific enolase (NSE), the y fraction of enolase, as a specific marker of disease evolution or treatment efficiency. Creatine kinase (CK) BB isoenzyme was also frequently detected in serum from such patients. We propose a therapeutic follow-up protocol using spectrophotometric measurement of CK and enolase activity and electrophoretic separation of isoenzymes.

Normal CK serum values are less than 130 units/L (BB isoenzyme, 0 percent) and 5 to 25 units/L for enolase (NSE fractions [y + yy] less than 10 percent).

The following observation shows the results of this study in a 60-year-old patient. The patient had a small cell lung cancer of the left upper lobe with supraclavicular lymph node involvement. He was treated with chemotherapy (adriabastin, vepeside, and cyclophosphamide). Blood samples were collected (Fig 1) before treatment (Do), after the first chemotherapy treatment (D + 3), before the second treatment (D + 30), and during relapse (D + 150).

An increase of NSE enzyme level at D + 3 was probably due to enzyme release from tumor cell necrosis under treatment. At D + 30, the patient showed important clinical and radiologic improvement. He was in complete remission for several months and enzyme level (NSE and CK BB isoenzymes) returned to and remained at normal levels. Increase of enzyme levels at D + 150 was the first biologic sign of relapse, and the patient developed bone metastases within weeks.

These enzyme activity measurement techniques present several