Pneumothorax Evacuation

To the Editor:

We appreciated the very interesting article by Dr. Pavlin and colleagues in Chest (1996; 92:70-74) regarding reexpansion hypotension (RH), and the related editorial comment. We reviewed our series of 400 spontaneous pneumothoraces, treated by evacuation, that have occurred since 1974 and found that we never had any case of RH or reexpansion pulmonary edema (RPE). We observed that, soon after beginning evacuation of the pneumothorax (either persistent or recent), some patients complain of severe pain inside the affected thorax side and cough; we immediately clamp the drainage tube for 15 min and then release the clamp for a few minutes until pain and cough begin again. With this method it can take a few hours before the drainage tube can be left continually open. On the other hand, Dr. Pavlin and colleagues and others maintain that the cause of RH and RPE is the rapidity of evacuation and not the duration of pneumothorax.

We believe that our method of gradual drainage, guided by chest pain and cough, could prevent this serious complication which, in some cases, is also fatal.

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REFERENCE


Erratum

To the Editor:

There are some regrettable errors in Table 2 in the Special Report, "International Symposium on Lung Sounds" in the August, 1987 issue (Chest 1987; 92:342-45). The Japanese translation of continuous, low-pitched sounds was inverted and reversed from right to left. The Portuguese terms are incorrect. Dr. Bohadana's original recommendations and the correct Japanese translations are shown below.

Table 2—Lung Sound Nomenclature

<table>
<thead>
<tr>
<th>Japanese</th>
<th>Portuguese</th>
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<tbody>
<tr>
<td>Discontinuous</td>
<td>擠髮音</td>
</tr>
<tr>
<td>Fine</td>
<td>水泡音</td>
</tr>
<tr>
<td>Coarse</td>
<td>Estertores finos</td>
</tr>
<tr>
<td>Continuous</td>
<td>Estertores grossos</td>
</tr>
<tr>
<td>High pitched</td>
<td><a href="%5B(i)%5D">ふえ</a> Sibilos</td>
</tr>
<tr>
<td>Low pitched</td>
<td><a href="%5B(i)%5D">いびき</a> Roncos</td>
</tr>
</tbody>
</table>

We apologize for these errors.

David W. Cugell, M.C., F.C.C.P.
Chicago

Extrathoracic Lymph Node Metastases In Malignant Pleural Mesothelioma

To the Editor:

In a recent report, Kim et al (Chest 1986; 91:279-81) present an interesting case of a 52-year-old man with malignant pleural mesothelioma diagnosed by axillary lymph node biopsy. In a review of 183 autopsied cases of this tumor from the medical literature, 44 percent were found to have neoplastic involvement of the hilar and mediastinal lymph nodes. Interestingly, only two cases (1 percent) had axillary lymph node involvement.

Prompted by this report, we reviewed 77 autopsy-confirmed cases (44 men, 33 women) of malignant pleural mesothelioma available at the Canadian Tumor Reference Center. The cases ranged in age from 23 to 89 with a mean of 61 years. Thirty-eight (49 percent) had documented asbestos exposure. At autopsy, 34 (44 percent) were found to have lymph node involvement, 31 (41 percent) of whom had
neoplastic involvement of the hilar and mediastinal nodes. Only one case (1 percent) had metastatic disease of the axillary lymph nodes, while an additional subject was found to have supraclavicular node involvement. An additional six cases showed metastases to abdominal lymph nodes. Therefore, eight (10.4 percent) had extrathoracic lymph node metastases.

Although we consider these 77 cases highly selected, the pattern of lymph node metastases in this series closely parallels that found in the review of Kim et al; in particular, the rare occurrence of axillary lymph node metastases. These data provide further evidence of a discrepancy between the observed and expected frequency of axillary lymph node involvement in malignant pleural mesothelioma and support the suggestion of Kim and colleagues of a prospective study to determine the true frequency of peripheral lymph node involvement associated with this disease.

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Kevin Smith, M.D., M.P.H.,
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To the Editor:

My colleagues and I thank Dr. Huncharek and Dr. Smith for their interest in our report and are pleased to note the results of their review.

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Milwaukee

Foreign Body Retrieval

To the Editor:

In a recent review of foreign bodies in the tracheobronchial tree (Chest 1987; 91:730-33), Weissberg and Schwartz state that for removal of the aspirated foreign body the open tube (rigid) broncoscope is "undoubtedly" the instrument of choice, although reference is made to a report by McCullough (Chest 1985; 87:270-71) in which there was successful removal of a pair of forceps using a Dormia stone basket through a permanent tracheostomy.

The following case report, like that of McCullough, suggests that rigid bronchoscopy may be quite unnecessary even to remove large, bulky foreign bodies.

CASE REPORT

A 58-year-old man presented to the outpatient department with a feeling of something sticking at the back of his throat after eating homemade turkey soup. Indirect laryngoscopy was unremarkable and the patient was discharged home, only to return the following morning having woken during the night with episodes of cough and wheezing. A chest x-ray film taken that morning was reported as normal and, although there was bilateral wheeze on auscultation, the patient clearly localized his problems to the left chest.

Following therapy with atropine IM and topical xylacaine, with supplemental O2 via nasal cannulae, the Pentax FB 19H bronchoscope was introduced through the mouth into the tracheobronchial tree and a turkey vertebra was identified in the left main bronchus. Attempts to grasp this with biopsy forceps (including those used routinely at gastroscopy) served only to dislodge the foreign body which then became firmly lodged in the right bronchus intermedius.

An imaginative OR nurse questioned whether the snare used at colonoscopy for polypectomy would slide down the large single channel of the fiberscope and, as this passed easily through the scope, the turkey vertebra was snared with the transverse processes horizontal to the trachea. In this position, however, it was felt that the transverse processes would damage the vocal cords and the bone was released and snared again, on this occasion with the transverse processes perpendicular to the trachea. The scope, snare and foreign body were easily removed per orum. The vertebra measured about 2 cm in its greatest diameter.

DISCUSSION

With the advent of large, single-channel fiberoptic bronchoscopes, foreign body retrieval from the tracheobronchial tree—at least in adults—may be satisfactorily attained using large baskets such as those used for removing colonic polyps. Such a technique allows for patient comfort and early discharge from hospital or emergency room.

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Foreign Body Retrieval

To the Editor:

Thank you for the opportunity to respond to Dr. Atkinson's comments. We wish to make it clear that we do not reject the use of the flexible bronchoscope. Indeed, it can be helpful occasionally, and several papers—not one—describing its use were quoted in our article. However, these are exceptions rather than the rule. Such is also the case described by Dr. Atkinson. It is our strong conviction that, in nearly all those exceptional cases, the rigid bronchoscope could have been used with equal success and probably with greater ease. In fact, we believe that the turkey's vertebra in Dr. Atkinson's case became dislodged because a flexible biopsy forceps was used rather than a large-size rigid grasping forceps. Had Dr. Atkinson used a rigid instrument, this complication probably would not have occurred.

Moreover, we wish to stress a more important point. The great majority of patients who aspirate foreign bodies are infants and children. In our series, children constituted 78.8 percent of the group; 39.4 percent were infants below the age of two years. How does Dr. Atkinson propose to control the airway in these tiny subjects? How many would have suffocated had we used the flexible rather than the open-tube bronchoscope?

We appreciate the opportunity to read Dr. Atkinson's comments, but we do stand by our conviction that the rigid bronchoscope is the instrument of choice in the management of tracheobronchial foreign bodies.

Doc Weissberg, M.D., F.C.C.P, and
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Department of Thoracic Surgery,
Tel-Aviv University Sackler School of Medicine,
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Recognizing Pulmonary Torsion

To the Editor:

Shorr and Rodriguez (Chest 1987; 91:927-28) reported an interesting case of spontaneous torsion of an entire lung. As observed in previous references, preoperative diagnosis failed in the presented case despite repeated bronchoscopic examinations. The authors conclude their report by postulating that a bronchogram with or