pulmonary function tests to support this hypothesis, as decreased vital capacity and total lung capacity could be due solely to parenchymal lung disease. Measurement of transdiaphragmatic pressure would have been one way to further assess respiratory muscle function. Unfortunately, our patient’s pulmonary function had normalized on therapy before the performance of this test could be arranged.

The case reported by Drs. Braidy and Poulson demonstrates that respiratory muscle weakness does occur in adult onset Still’s disease, as it does in other rheumatologic diseases. Although the patient we described may represent another case of Still’s disease with associated respiratory muscle dysfunction, the presence of parenchymal lung infiltrates decreases the specificity of the available data and therefore does not allow us to make this claim.

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REFERENCE

Serious Complications of Fiberoptic Bronchoscopy

To the Editor:

Fiberoptic bronchoscopy has assumed a major place in the evaluation of pulmonary disease, with low morbidity and rare mortality. Increasingly, individuals seek to attribute untoward events surrounding diagnostic or therapeutic procedures to the procedure, lack of skill of the physician, or failure to adequately monitor the patient. We would like to report several would-be complications of fiberoptic bronchoscopy which we have seen during the past year.

From 1984 to 1987, pulmonary physicians at the Naval Hospital/Bethesda have performed over 1,500 diagnostic fiberoptic bronchoscopic examinations (with or without transbronchial biopsy), approximately three-fourths as outpatients, with no mortality or life-threatening cardiovascular morbidity, and no patient experienced myocardial infarction or stroke. In all cases supplemental oxygen was given, and in less than 5 percent was cardiac monitoring used. This experience differs from a recent recommendation that cardiac monitoring be used routinely during fiberoptic bronchoscopy.

On the other hand, we have seen three patients who experienced life-threatening “complications” within 24 hrs prior to diagnostic bronchoscopy. Two patients developed myocardial infarction at home on the evening prior to the procedure, while one patient experienced a cerebral infarction with aphasia and hemiparesis in the waiting area prior to bronchoscopy. While these events in themselves prove little, they accentuate the difficulty in attributing complications to physicians or diagnostic procedures. These events are frequently unavoidable, particularly in an elderly population with a background of heavy tobacco use and risk of generalized atherosclerosis. None of these patients had premonitory symptoms or unstable angina. We report this chance experience not to diminish the importance of peer review and cardiac monitoring in patients deemed at increased risk, but to remind the medical community of the vicissitudes and implications of guidelines to medical practice.

REFERENCES

This opinion is solely that of the authors and does not reflect the official opinion of the Naval Service, the Naval Medical Department, or the Department of Defense.

Alcoholism and Hypertension

To the Editor:

The “Management of resistant hypertension” by Ram1 is a comprehensive evaluation of this facet of therapy. One additional factor, however, was omitted from his discussion and merits consideration. The medical literature about the association of high blood pressure and chronic alcoholism admittedly is equivocal, but a recent personal study suggests that poor black alcoholic subjects have a 20 percent greater chance of acquiring hypertension than control subjects. The relative risk of high blood pressure associated with alcoholism was 1.20 and the odds ratio was 1.23. Confidence levels were excellent in both calculations. When these values were subjected to chi-square analysis at a P value of 0.05 and one degree of freedom, they were fully acceptable. The study had an estimated 97 percent chance of detecting a 1.2 times increased association of hypertension with alcoholism. The routine investigation of all patients with hypertension should include an inquiry about alcoholism. Abstinence from alcohol alone may permit a reduction of elevated blood pressure in some subjects. Alcoholics may also find compliance with customary drug therapy more difficult because of their alcoholic addiction.

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REFERENCES

To the Editor:

I fully agree with Dr. Miller’s comment that alcoholism may be an important cause of resistance to antihypertensive therapy. I also agree that, in the evaluation, an inquiry about alcoholism should be made. I am grateful to Dr. Miller for bringing up this important, potentially remediable factor.

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University of Texas Health Science Center; Dallas

Automatic Staplers and Bronchopleural Fistulas

To the Editor:

It is with great interest that I read the article by Smiell and Widmann on “Bronchopleural fistulas after pneumonectomy: a problem with surgical stapling” (Chest 1987; 92:1056). In this paper,