Communications to the Editor

Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Specific permission to publish should be cited in a covering letter or appended as a postscript.

Sudden Death and Pacemakers

To the Editor:

In "Conduction system in a trained jogger with sudden death," Bharati et al (Chest 1988; 93:348-51) report on a 47-year-old athletic man who died suddenly three months after receiving a permanent pacemaker for second degree atrioventricular block associated with symptoms of not feeling well. Autopsy showed left ventricular hypertrophy and some disturbance of the cardiac conduction system. However, the cause of sudden death is not clear. The possibility of a direct or indirect role of the pacemaker is not discussed.

First, in a 47-year-old divorced athlete the implantation of a permanent pacemaker could be psychologically devastating. Accordingly, what were the results of the toxicologic studies?

Secondly, permanent pacemakers in general (and dual-chamber pacemakers in particular) can be arrhythmogenic. Certainly, if no other causes are found, a tachycardia evoked by the pacemaker could have contributed to his death.

Howard S. Friedman, M.D., F.C.C.P.
SUNY Health Science Center
Brooklyn

To the Editor:

Our thanks to Dr. Friedman for his interest in our article. According to the pathologist and clinician, toxicologic studies were not done because there was no suspicion of foul play in this case. As per the clinical history, the man was living a clean life and therefore the question never arose.

As far as permanent pacemakers are concerned, they are all of the inhibited variety. Unless there is a runaway pacemaker, one cannot possibly think how a pacemaker could be arrhythmogenic. It is possible that the pacemaker totally failed; however, the pacemaker was tested and found to be in good order.

On the other hand, the conduction system showed an abnormally located atrioventricular (AV) node which had tenuous connection with the surrounding atrial musculature. The AV node at its junction with the His bundle showed fat, fibrosis, myocardial disarray and mononuclear cell infiltration. There was fibrosis of both bundle branches with increased aging changes of the summit of the left side of the septum. The above findings are sufficient from a pathologic standpoint to create a milieu for arrhythmogenicity and sudden death.

The dual chamber pacemaker gave him maximum atrial contribution. However, the ultimate dual chamber pacemaker has not been invented that is a sensor type dual chamber unit. We only have single-chambered sensor type pacemaker units in which body motion, pH, O2 or an evoke response would alter the rate according to need, particularly when jogging.

Sarooja Bharati, M.D. F.C.C.P.
Palo Alto, California

Clinical Predictors of Malignancy

To the Editor:

Poe et al1 recently performed an interesting fiberoptic bronchoscopic study in patients with hemoptysis and normal or nonlocalized finding on the chest roentgenogram to determine which clinical predictors are the best to diagnose primary malignant neoplasm, to identify specific diagnoses other than bronchitis and to locate the active bleeding site. They conclude that the presence of two of the three factors associated with malignancy (over 50 years of age, male, and smoker of 40 pack-years or more) or bleeding in excess of 30 ml daily identified 100 percent of patients with bronchogenic carcinoma and 82 percent of all diagnoses obtained by fiberoptic bronchoscopic procedures.

Between January, 1985 and February, 1988, 245 of the 1,120 consecutive fiberoptic bronchosopies we performed were due to hemoptysis. Of these 245, 102 patients (45 percent) had a normal or nonlocalized finding on chest roentgenogram, and all had two or more negative sputum smears for acid-fast bacilli and Papanicolaou staining. Fiberoptic bronchoscopy procedures revealed a specific cause for bleeding in 15 patients: bronchogenic carcinoma in three (3 percent); tuberculosis (positive bronchial washing and/or bronchial biopsy for Lowenstein cultures) in three (3 percent); bronchiectasis in six and non-tuberculosis, upper airway source, and sarcoidosis in one case each. In the remaining 86 patients, 57 had endoscopic evidence of bronchitis. No diagnosis was established in the other 30 patients. Our results showed a similar incidence for both bronchogenic carcinoma and tuberculosis disease (two endobronchial tuberculosis). However, only one of three patients with tuberculosis met Poe's criteria for fiberoptic bronchoscopy indication.

In countries such as ours with a high incidence of tuberculosis,2,3 the disease especially affects young people of both sexes.4 In such cases, the disease is usually primary and may evolve with exclusively endobronchial involvement. Furthermore, the antecedent of smoking is of little relevance when diagnosing suspected tuberculosis. Keeping this in mind, together with the high performance of fiberoptic bronchoscopy in the diagnosis of tuberculosis,5 we conclude that a more liberal use of fiberoptic bronchoscopy in patients with hemoptysis and normal or nonlocalized finding on chest roentgenogram could be justified in those countries with a high incidence of tuberculosis.

Javier de Gracia, M.D.;
Carlos Braco, M.D.;
Ramón Orriola, M.D.;
Rafael Vidal, M.D.;
Gabriel Sampol, M.D., and
Fernando Morell, M.D.,
Service de Pneumologia,
Hospital General Vall d’Hebrón,
Universidad Autónoma de Barcelona, Spain

Downloaded From: http://journal.publications.chestnet.org/pdftoaspx?url=/data/journals/chest/21587/ on 06/21/2017