To the Editor:

As noted by Dr. Kanter, Watts et al previously reported a case of bronchogenic cyst that compromised right pulmonary artery blood flow and was associated with a reversible unilateral perfusion defect. We were unaware of this prior report and are grateful to Dr. Kanter for bringing it to our attention. The cases are indeed quite similar. In our report, we emphasized that a unilateral perfusion defect on lung scan was not likely due to pulmonary embolism, but rather to extrinsic compression of a pulmonary artery. This observation applied to our patient who presented with chest pain, dyspnea, and normal findings on chest film, initially raising the question of pulmonary embolism.

Kenneth A. Berkowitz, M.D., and Robert L. Smith, M.D., F.C.C.P.
New York Veterans Administration Medical Center,
New York

Pulmonary Artery Catheters
The Controversy Continues

To the Editor:

I have followed with great interest the interchange of articles regarding the hazards and benefits of pulmonary artery catheters and have to say that my sympathies lie strongly in Dr. Eugene Robin's camp. However, in the May 1988 issue of Chest is an article by Mark D. Altschule which elegantly lambasts the use of Swan-Ganz catheters in the monitoring of fluid distribution across pulmonary capillary walls. While I strongly support his conclusion, it appears that he fails to recognize that the purpose of wedge pressure measurement is determination of optimal left ventricular function and forward cardiac output rather than as a predictor of pulmonary edema. While I agree with Dr. Robin that these measurements are often inaccurate, invalid and misapplied, it is fair to say that Dr. Altschule fails to discuss the real purpose of wedge pressure measurement.

David Shander, M.D., F.C.C.P.
Director, Coronary Care Unit,
Rose Medical Center,
Dencer

To the Editor:

Dr. Shander is in error in assuming that Dr. Eugene Robin—or anyone else—knows what the pulmonary artery wedge pressure measures under the changing conditions of vasomotor activity in the pulmonary vascular system. It is all a guess or, at best, an opinion. In my opinion, the measurement may mean a dozen different things to a dozen different observers.

Mark D. Altschule, M.D.
Boston

Adverse Effects of Amiodarone at Low Doses

To the Editor:

We have read with great interest Kowey et al's article showing that low doses of amiodarone appear to be safe and effective. However, they emphasize that potentially life-threatening complications occur frequently and that amiodarone therapy should be used only for patients with resistant and/or life-threatening arrhythmias, with periodic monitoring. A higher incidence of adverse effects associated with long-term amiodarone therapy has been reported for American patients treated with high doses (greater than 400 mg/day) than for European patients treated with lower doses (200 to 300 mg/day). We have also shown that amiodarone-induced adverse pulmonary effects are less frequent when a low dose is given. We wish to report our own prospective study of a group of patients treated with low doses of amiodarone. There were 48 consecutive patients (33 men, 15 women) 32 to 91 years of age (mean 69 ± 12 years) on long-term treatment with amiodarone at an average daily dose of 208 ± 61 mg (range 122 to 880 mg) for a mean period of 13 ± 10 months (range 0.1 to 36 months) with mean total dose of 78 ± 59 g (range 1.2 to 216 g). Twenty-one percent (44 percent) presented with supraventricular tachyarrhythmias, 15 percent with ventricular arrhythmias, and 12 percent with ventricular and supraventricular arrhythmias. Ten of the patients (21 percent) underwent intravenous loading. Thirty-six percent (75 percent) were followed with clinical and laboratory examinations for more than two months. Follow-up was missed in 25 patients (52 percent). Six patients (12 percent) died (one suddenly three days after the beginning of treatment; two because of cardiac failure caused by dilated cardiomyopathy two months after the beginning of treatment; two, whose deaths were non-cardiac, after one and four months; and one after nine months from pulmonary fibrosis with superinfection). Another seven patients (14 percent) were withdrawn by private physicians after three, seven and 14 days and three, ten, 17 and 32 months. Two patients (4 percent) were withdrawn because of recurrent arrhythmias after two and 25 months. Seven patients (14 percent) were lost to follow-up: one after 15 days; two after two months; and the other four after three, four, seven and eight months. Another three patients (6 percent) were withdrawn for serious adverse reactions. Twenty-four patients (67 percent) presented side effects (Table 1), 12 (33 percent) with only one and the others with two or more side effects due to amiodarone therapy. Four patients (11 percent) had serious side effects necessitating withdrawal of amiodarone (pulmonary fibrosis in three patients and hyperthyroidism in one). Six (17 percent) had serious side effects that did not necessitate the withdrawal of amiodarone. One, who had subclinical hypothyroidism with an elevated titer of antithyroid antibodies before beginning treatment, developed clinical hypothyroidism and is on substitution therapy with triiodothyronine. Another had a high blood glucose level (559 mg/dl), with normal blood insulin, that became normal within one month. Four patients had greater than 20 percent decreases in DLCO. Nineteen patients (53 percent) had laboratory test result abnormalities. Twenty-three patients (48 percent) are still on amiodarone treatment. These results show a higher frequency of serious side effects than those reported by Kowey et al or by other groups. Serious adverse effects appeared in our patients treated for a long-term and on high total doses of amiodarone. Nonserious adverse effects were less frequent, perhaps because we did not consider corneal microdeposits. Our observations indicate that the drug should be used for life-threatening arrhythmias only when other anti-arrhythmic drugs are ineffective, with careful monitoring of the patients by frequent clinical, radiologic and laboratory examinations.

Valeriano Foresti, M.D.; Elena Parissio, M.D.; Roberto Pepe, M.S.; Nadia Scolari, M.D.; and Antonio Villa, M.D.
Fatebenefratelli—Oftalmico Hospital, Milan, Italy

Communications to the Editor