Foreign Body Aspirate Extraction

To the Editor:

We read with great interest the paper by Weissberg and Schwartz (Chest 1987; 91:730-33) where they report their experience in a large series of patients (66) with foreign bodies (FB) in the lower airways. In 58 patients there was successful removal of the FB, either by means of extraction with the rigid bronchoscope (RB) in 55, or by cough shortly after the procedure in the remaining three. They stated that the fiberoptic bronchoscope (FOB) "was used initially but proved inadequate."

In the last 11 years, we have had 40 cases of FB aspiration (11 patients less than 2-years-old, 12 patients between 2 and 10 years and 17 patients 11 years or older). At first we used the FOB (Olympus IT and BF-3) for diagnosis but gradually we employed it more often for treatment. Of the 40 patients, 37 had successful removal of their FB; 21 (52.5 percent)—including all the patients less than 2-years-old—with the RB (Storz series with standard forceps); 11 (27.5 percent) with FOB and in all cases but two with the standard biopsy forceps and/or Fogarty balloon; and five (12.5 percent) with RB after the failure of FOB. One patient (2.5 percent) expectorated a vegetable seed shortly after FOB. The remaining two patients (5 percent) refused surgery after the failure of RB and were lost to follow-up. Like the Weissberg and Schwartz series, many cases (15/40) lack a clear history of aspiration.

We think that the differences observed between the two series can be explained, at least partially, in two ways. 1) We do not reserve FOB for more peripherally located FB. 2) Our patients showed an age distribution somewhat older than that of Weissberg and Schwartz.

Taking into account our 12/17 rate of success in the removal of FB with FOB, and with the availability of new accessories (Dormia basket, four prong forceps, etc), we believe that FOB is the procedure of choice for patients over 10-years-old in whom FB aspiration is suspected (or already diagnosed by x-rays examination), with the exception perhaps of the patient with serious ventilatory compromise where a secure airway can be established by means of the RB.13

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REFERENCES


To the Editor:

Thank you for the opportunity to respond to Dr. Nuñez's letter. We do not really disagree. There is use for the flexible bronchoscope in removal of foreign bodies and, as more experience is gained, it will probably become more popular although neither better nor more suitable for removal of foreign bodies than the rigid instrument. One important advantage of the rigid bronchoscope is that it enables ventilation of very narrow air passages, which is particularly important in children. As Dr. Nuñez correctly noted, the age distribution of his patients is different than in our group: 78.5 percent of our patients were infants and children; 39.4 percent were infants below the age of 2 years. In these tiny patients, airway control is virtually impossible with the flexible instrument; it is relatively easy with the open-tube bronchoscope.

There is no doubt that the well educated bronchoscopist, whether a pulmonologist or thoracic surgeon, should know how to handle both flexible and rigid bronchoscopy techniques. For this purpose a resident or a fellow should be appropriately trained and become proficient in the use of both kinds of instruments. Both are good, each for its own indications.

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Inspiratory Resistance Training for Pulmonary Rehabilitation

To the Editor:

Pulmonary rehabilitation programs are often relegated to "step-child" status in hospital outpatient departments due to personnel and cost constraints. Moreover, the efficacy of such efforts in achieving measurable benefits has been difficult to assess, further inhibiting widespread support.1

We have undertaken a demonstration project to justify development of outpatient pulmonary rehabilitation services in our community. Sixteen severe COPD patients were given intensive training with an inspiratory resistance device4 at weekly intervals for six weeks. Inspiratory resistance was increased at each session according to individual tolerance. Pulmonary function and questionnaires of functional status5 were assessed at each session. All patients were instructed to use the device twice daily for 15 min at home between training sessions.

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