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Positioning vs Vibrations in Chest Physiotherapy

To the Editor:

I enjoyed the interesting article by Stiller et al.,1 which appeared in the December 1990 issue of Chest.

The question was asked whether positioning or vibrations was the effective component of treatment. Research on vibrations has shown as many positive as negative outcomes,2 which is why vibrations are no longer performed routinely. Accurate positioning, however, is used effectively for the treatment of atelectasis, ventilation-perfusion mismatch, and breathlessness.3 Positioning can be incorporated into a patient's management plan 24 h a day, and it is cheap.

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Breakage of Forceps Valve Cover and Its Introduction into a Patient

An Unusual Complication of Fiberoptic Bronchoscopy

To the Editor:

We would like to report an unusual complication that occurred while performing fiberoptic bronchoscopy using Olympus BF-P20 equipment (Olympus Corp, Lake Success, NY). After obtaining the bronchial brush biopsy specimen, a black object, apparently a foreign body, was visualized in the bronchus and was removed by suction. The object had a rubbery consistency, and it exactly matched a hole found in the rubber forceps valve cover of the bronchoscope (Fig 1).

The forceps valve cover is marketed as "semi-disposable," and there are no clear recommendations on the frequency of replacement. Replacement at our institution normally occurs after ten to 30 uses, especially when suctioning becomes suboptimal. The deterioration of the rubber could be due to multiple sterilizations with glutaraldehyde.

Figure 1. Photograph of the broken forceps valve cover (bottom) and foreign body retrieved (at right). A newer forceps valve cover (top) is shown for comparison.

This previously unreported complication of fiberoptic bronchoscopy should be noted by clinicians who perform this procedure. If unrecognized at the time of bronchoscopy, a small rubber foreign body will not be visible on chest roentgenography and could be responsible for unexplained pneumonia or atelectasis.

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Cromolyn for Cough Due to Angiotensin-Converting Enzyme Inhibitor Therapy

Preliminary Observations

To the Editor:

Although estimates of incidence vary, cough is now recognized as a common complication of angiotensin-converting enzyme (ACE) inhibitor therapy. By virtue of the study design, the report by Sebastian et al.,3 which appeared in the January 1991 issue of Chest, provides the best estimate available of the incidence of this troubling side effect in male patients.

The problem was first seen with enalapril, but is now recognized with all of the ACE inhibitors, including several not yet released for use in this country.4 Cough is severe enough to require cessation of therapy in about 10 percent of patients, and discontinuation of ACE inhibitor therapy is the only treatment suggested by Sebastian et al.4 For hypertensive patients, alternative drugs can usually be found, but for patients with severe congestive heart failure, ACE inhibitors are less easily replaced because of their potent "afterload reduction" effect. In these cases, a treatment for cough associated with ACE inhibitors would be of great value. In a review of 115 articles on the subject of cough due to ACE inhibitor therapy, I