"multiple metabolic factors," including hypoxemia and a high normal theophylline level, had caused the seizure.

One year later a bronchopleural fistula developed at the bronchial stump of a prior upper lobectomy (performed for control of cavity MAI infection ten years previously). Hospitalization ensued, and the patient was treated for lower lobe pneumonia with cefuroxime. An infectious disease consultation suggested that he be discharged on a regimen of ciprofloxacin, 500 mg twice daily, to treat both active MAI and community-acquired pathogens.

One week after discharge the patient presented to the emergency room in status epilepticus. Administration of diazepam to control seizures caused a respiratory arrest, and intubation and mechanical ventilation were unsuccessful due to rupture of the bronchopleural fistula. The serum theophylline level was 10.5 µg/ml and the serum sodium concentration was 131 µg/ml. No other cause of seizure could be located, although the head CT scan was not completed due to his cardiac arrest in the CT room.

The Physicians' Desk Reference® lists seizures as a possible adverse reaction associated with ciprofloxacin, but it should be emphasized that they can occur in the presence of a normal serum theophylline level. A recent literature review revealed only one case of seizures associated with a quinolone antibiotic. With the increasing use of this class of antibiotics, it is critically important that physicians be aware of the potential for seizure activity in the absence of an elevated serum theophylline level.

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REFERENCES

Long-term Postthoracotomy Pain

To the Editor:

Dajczman et al® deserve our thanks and congratulations for their superb study of protracted postthoracotomy pain, which appeared in the February 1991 issue of Chest. Though common, postthoracotomy intercostal neuralgia is rarely mentioned in the medical literature and is dismissed by many thoracic surgeons as a banal, very transient postoperative sequela. Patients, however, often interpret it as a recurrence of their malignancy or are puzzled by its accompanying symptoms (eg, intense hyperesthesia or paresthesia in an anesthetic area, muscular twitches, intercostal hernia).

The diagnosis is easily confirmed by bupivacaine intercostal blocks at the operative-site interspace. Complete, albeit transient, relief should reassure the patient that the pain is indeed incisional. But providing definitive relief is difficult, as the authors rightly point out. Neurolysis, cryolysis or thermoacoagulation, and peripheral neurosurgery have been disappointing. Such failures after successful local anesthetic blocks are typical of deafferentation syndromes. Indeed, Sunderland® has attributed postthoracotomy neuralgia to avulsion of the intercostal nerve during surgery. However, some symptoms, such as trigger points and aggravation of the pain with chest wall movements, point to scar or suture entrapment of the nerve or of a neurora. The treatments for deafferentation pain (transcutaneous electrical nerve stimulation, anticonvulsants, tricyclic antidepressants, nonsteroidal anti-inflammatory drugs) may be helpful. Dorsal root entry zone ablation seems not to have been tried.®

Surgeons have ignored a 1973 report® that postthoracotomy intercostal neuralgia is rare when rib resection is avoided and deep muscle relaxation is used for access to the lung. These results need to be confirmed.

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To the Editor:

In response to the informative letter from Drs Defalque and Boyd, we are in agreement on the need to confirm benign protracted postthoracotomy pain in those patients suspected of suffering from this syndrome. By doing this, two purposes would be served. First, it would relieve the concern of the patient that he has recurrent cancer. Second, it would stimulate concentrated effort to find therapeutic interventions that may have some benefit for the individual.

We agree that attention should now be focused on strategies and therapeutic modalities to prevent or treat this troublesome syndrome. Transcutaneous electrical nerve stimulation, anticonvulsants, tricyclic antidepressants, nonsteroidal anti-inflammatory drugs, and dorsal route entry zone ablation require investigation. However, it must be remembered that in most cases the intensity of pain is such that only simple analgesics are required. For those with more severe pain, the above treatments warrant study. Since those with severe pain constitute only a small proportion of all those with chronic postthoracotomy pain, any prospective randomized trial to determine the efficacy of a treatment might require multicenter participation to achieve sufficient sample size. Hopefully, these communications will create interest in such endeavors within the medical community.

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Bronchoscopy Begets Bronchoscopy

Use of Fiberoptic Bronchoscope to Remove a Foreign Body Left Behind after Previous Bronchoscopy

To the Editor:

Since the invention of the flexible fiberoptic bronchoscope (FFB) by Ikeda® in the late 1960s, its advantages over the rigid bronchoscope (RB) have quickly become apparent, not only in diagnosis of pulmonary disorders but also in removal of foreign bodies from the