"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 cefoxorime. 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 10.8 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, I believe it is critically important that physicians be aware of the potential for seizure activity in the absence of an elevated serum theophylline level.

Michael B. Bader, M.D., F.C.C.P., Stoneham, Massachusetts

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Long-term Postthoracotomy Pain

To the Editor:

Dajczman et al desire 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 incisonal. But providing definitive relief is difficult, as the authors rightly point out. Neurolysis, cryolysis or thromboembolectomy, 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 neuroma. 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.

Ray J. Defalque, M.D., and
Guendolyn L. Boyd, M.D., F.C.C.P.,
Department of Anesthesiology,
University of Alabama,
Birmingham

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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.

Norman Wolkove, M.D., F.C.C.P., and
Esther Dajczman, M.Sc.A.N.,
Division of Pulmonary Diseases,
Sir Mortimer B. Davis-Jewish General Hospital,
Montreal

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
tracheobronchial tree, especially those difficult to reach with the RB. We present a case of removal of a cleaning brush from the tracheobronchial tree with use of an FFB.

A 27-year-old man was diagnosed as having stage IV non-Hodgkin’s lymphoma, on the basis of a cervical lymph node biopsy at a local hospital in July 1989. During the initial course of chemotherapy, he had a productive cough and a low-grade fever. An FFB study was done to rule out infection after increased gallium uptake was noticed in the left lower lobe. Bronchoalveolar lavage was performed, and transbronchial biopsy specimens were obtained from that area; according to the patient, the procedures went uneventfully. The study material was nondiagnostic.

The patient was admitted to the Cleveland Clinic Foundation in November 1990 for bone marrow transplantation after failure of multiple chemotherapy trials. A routine chest roentgenogram revealed a 1.5-cm-long, thin metallic foreign object in the medial portion of the right lower lung, with minimal surrounding fibrotic or inflammatory changes (Fig 1). We suspected that the object was the broken-off end of a cytology brush. Because the patient was to be subjected to an immunocompromised state, it was decided to remove the foreign body.

An FFB was introduced through a mouthpiece; the endobronchial examination was unremarkable except for the presence of a metal brush in the distal portion of the anterior basal segment of the right lower lobe. Due to the cough induced by the FFB, the object moved more distally to become out of visual range. Under fibroscopy, a basket forceps was introduced to the site of the object. The basket forceps was then closed, and the object within the closed forceps and the FFB were withdrawn gradually up to the mouth. Close examination of the foreign object revealed it to be the broken-off distal end of an FFB cleaning brush (Fig 2).

Apparently the physician who performed the initial bronchoscopy was not aware of the incident. The distal end of the cleaning brush possibly broke off in the channel while the instrument was being cleaned prior to the procedure and was then dropped into the patient’s endobronchial tree during bronchoscopic maneuvers.

This case illustrates several points. First, nondisposable instruments used during bronchoscopy should be examined periodically for their durability. Damaged instruments should be replaced or repaired. Second, the channel of the FFB should be inspected before it is stored for the next procedure. Broken cleaning instruments, mucus plugs, blood clots, dried-up radiographic contrast material used for bronchograms, metal tips from a laser fiber, and broken sapphire probes used for laser procedures are some of the objects that can be inadvertently left in the channel. Third, this case supports the growing notion that the FFB can be safely used to remove foreign objects from the endobronchial tree. We also believe that the capability of using fancy flexible accessories, such as baskets, snares, and Fogarty catheters, puts the FFB at an advantage over the RB in removing distally placed foreign objects.

Hang X Khalil, M.D., and Atul C. Mehta, M.D., F.C.C.P.,
Department of Pulmonary Disease,
Cleveland Clinic Foundation,
Cleveland Ohio 44106

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Use of pH Paper to Reflect Gastric pH

To the Editor:

We read with great interest the study of Layon et al.1 which appeared in the March 1991 issue of Chest. While the results are intriguing, we question their use of pH paper as described in the Methods section. In our study of its utility, we found pH paper to be inaccurate in its ability to reflect gastric pH.2 Like Layon et al., we performed a blinded test of clear buffered solutions, comparing pH paper to a calibrated pH electrode. Using this comparison, we found the sensitivity and specificity of pH paper in predicting a pH of <4 to be 100 percent. However, when actually comparing gastric pH of <4 as read by pH paper to that determined with a pH electrode, we found the sensitivity of the paper to be only 66.7

Figure 1. Posteroanterior chest radiograph shows metallic foreign body (arrow) in right lower lung.

Figure 2. Bronchoscopy, cleaning brush after being extracted from the tracheobronchial tree.

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