Thromboembolism Associated with Acquired Immunodeficiency Syndrome

To the Editor:

Noninfectious thromboembolic disease is infrequently considered in the differential diagnosis of acquired immunodeficiency syndrome (AIDS)-related pleuropulmonary complications. Circulating anti-phospholipid antibodies, though commonly detectable, are usually not associated with thrombotic complications in patients with human immunodeficiency virus (HIV) disease.1 Stimulated by the report of a case of unexplained pulmonary embolism,2 which appeared in the September 1991 issue of Chest, we describe a second case, in which the perceived rarity of this condition in AIDS led to a delay in diagnosis.

A 37-year-old Haitian man presented with a three-day history of dyspnea, right-sided pleurisy, fever (maximum, 39.5°C), and scant hemoptysis. He had advanced HIV disease (CD4+ lymphocytes, 6/cu mm; prior cerebral toxoplasmosis) but had recently been stable and ambulatory on a regimen of zidovudine. A chest roentgenogram showed a moderate right pleural effusion, consolidation of the underlying lung, and a small left effusion. The right-sided exudate contained 17,500 erythrocytes and 8,500 leukocytes (88 percent polymorphs) per cubic millimeter. Penicillin and cefotaxime were administered for suspected bacterial pneumonia. Cultures of blood, sputum, and pleural fluid were unrevealing.

The patient's symptoms and fever diminished over several days, but on day 10 he developed acute left pleurisy, tachycardia (120 beats per minute), and tachypnea (30 breaths per minute), followed by recurrence of fever (38.6°C) and recurrence of the left-sided effusion. Uncontrolled infection remained the focus of diagnostic thinking for another week, until radionuclide scans showed multiple, bilateral segmental perfusion defects in regions with normal ventilation, indicating a high probability of pulmonary embolism. Venous Doppler examination and computed tomography of the abdomen revealed no source of emboli. Routine coagulation studies on admission were normal, as were protein C, protein S, and antithrombin III levels. Circulating lupus anticoagulant was not detected. The patient recovered with anticoagulant therapy alone.

We believe that pulmonary emboli accounted for this patient's entire presentation, although an initial right-sided bacterial pneumonia cannot be excluded. No antecedent risk factor for venous thrombosis was identified. The predisposing role of HIV disease itself, if any, remains speculative. This and other recent cases4 emphasize the need to consider thromboembolism in AIDS patients, despite their young age and the usually infectious nature of pleuropulmonary disease with fever in this setting.

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References
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Pulmonary Intubation with Nasogastric Tubes

To the Editor:

I read with interest the "Roentgenogram of the Month" feature1 in the November 1991 issue of Chest, in which pulmonary intubation with nasogastric tubes was discussed. This excellent discussion does not, however, address methods to prevent this common complication.

Roubenoff and Ravich2 describe a two-step method of feeding tube insertion, whereby the tube is first advanced to a point estimated to be at the xiphoid process and its position is then confirmed by an anteroposterior chest roentgenogram, which should show no lateral deviation from the midline, as occurs with bronchial intubation. The tube is then advanced into the stomach, and the position is confirmed with an abdominal x-ray film.

At the University of New Mexico Hospital Intensive Care Unit, we encountered eight episodes of pulmonary intubation in 170 instances of attempted nasogastric feeding tube placement (4.7 percent incidence) over a two-year period. We have modified our method of nasogastric feeding tube placement by rotating the patient's head to either shoulder. This simple maneuver causes deviation of the feeding tube tip from the midline laryngeal opening; this can be verified by visualization of the pharynx. With reeducation of physicians and nursing staff in the passage of fine-bore feeding tubes and meticulous documentation by a single abdominal x-ray film of appropriate tube location, this problem has not recurred.