over a one-year period of observation. While this cannot eliminate the risk of pulmonary intubation, we recommend that this safe and simple modification be used for insertion of all fine-bore feeding tubes.

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Inadvertent Pericardiacophrenic Vein Catheterization

To the Editor:

A unique complication arose during an attempted percutaneous right subclavian vein catheterization. After insertion of the catheter, guide-wire withdrawal was met with resistance, followed by the unraveling of the outer coil-spring sheath. A chest radiograph demonstrated a portion of the wire in a seemingly intracardiac position. Upon exploration, the wire was found protruding through the distal branches of the pericardiacophrenic vein (Fig 1).

The pericardiacophrenic vein, the main vein of the pericardium, courses along the phrenic nerve and drains into the superior vena cava through the internal mammary (thoracic) vein. Its course parallel to the vena cava makes cannulation unlikely, although not impossible. In this case, a slight angulation of the guide wire caused by contact with the clavicle may have caused it to enter the vein. The coil-spring, anchored in the pericardium, unraveled upon withdrawal, exposing the broken-off piece of inner core, which does not have recoil and will break if bent too often. This case emphasizes again the element of chance associated with blind percutaneous procedures.

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Diagnosis of Tuberculous Pleural Effusion by the Detection of Tuberculostearic Acid in Pleural Aspirates

To the Editor:

I wish to comment on the article by Yew et al,1 which appeared in the November 1991 issue of Chest. The authors considered examination of pleural fluid for tuberculostearic acid (TBSA) to be unhelpful, mainly because of its low specificity (52 percent). This is in marked contrast to the results of our prospective study on the diagnosis of sputum smear-negative pulmonary tuberculosis by TBSA assay in bronchoscopic aspirate and bronchoalveolar lavage (BAL) specimens.2 This study was performed by the Department of Medicine, Chinese University of Hong Kong, in collaboration with the Department of Microbiology, which carried out the TBSA assay for both studies. Although the sensitivities of 52 percent and 68 percent for bronchoscopic aspirate and BAL specimens, respectively, are similar to the sensitivity for pleural aspirates in the study by Yew et al (68 percent), the specificities for bronchoscopic aspirate and BAL specimens were both 100 percent. We therefore concluded that TBSA assay of bronchoscopic specimens was useful for the rapid diagnosis of sputum smear-negative TB.

What is the reason for the remarkable difference in specificity for the different types of specimens processed in the same laboratory? Yew et al suggested that this might be related to release of TBSA from old subvisceral pleural foci in their nontuberculous patients. I would like to suggest an additional possibility. Conditions within a sizable pleural effusion rapidly become anaerobic. Since TBSA is also present in some anaerobic organisms, such as actinomycetes, it is possible that some false-positive results may be due to the presence of such organisms. In contrast, bronchoscopic aspirate and BAL specimens are almost inevitably obtained from well-aerated regions of the lungs, where anaerobes are unlikely to be present, so that the specificity is high. Therefore, the diagnostic value of TBSA in pulmonary tuberculosis seems to depend on the type of specimen assayed, being good for bronchial aspirates and BAL fluid but unsatisfactory for pleural aspirates.

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