Bronchoscopic Survey of Posttraumatic Infantile Ventricular Septal Defects

To the Editor:

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REFERENCES


To the Editor:

We have read the articles by Prakash et al.,1,4 which appeared in the December 1991 issue of Chest, and we commend them for their involved efforts with the ACCP bronchoscopy survey. Our comments specifically refer to the authors' recommendation4 that fluoroscopy be utilized to identify the "maximally abnormal" areas prior to transbronchial biopsy. While our data4 confirm that fluoroscopy will increase the yield from transbronchial biopsy of focal lesions, the yield from diffuse disease processes, such as sarcoidosis and lymphangitic carcinomatosis, are approximately the same between fluoroscopy and no fluoroscopy. This finding is further supported by a study published in 1988 involving 250 bronchoscopic procedures performed in patients with acquired immunodeficiency syndrome or human immunodeficiency virus seropositivity who had diffuse roentgenographic findings.4 In this study, the safety and the yield were favorable when transbronchial biopsies performed without fluoroscopy were compared to biopsies done with fluoroscopy. This study and ours together provide approximately 500 recent cases in which the fluoroscopy/no fluoroscopy question has been examined, and the concept of transbronchial biopsy without fluoroscopy has been shown to be safe and effective in diffuse disease. The American Thoracic Society deleted the recommendation for routine fluoroscopy with transbronchial biopsy in its official position paper on guidelines for fiberoptic bronchoscopy in adults.5

Finally, we concur with the authors' suggestion that additional studies may be beneficial when defining what the practice standard for bronchoscopy should be in North America. Only through meaningful interchange leading to consensus can such a standard be defined.

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preference and the effect of the topical anesthetic on the bronchoscopy procedure. After obtaining informed consent, we enrolled 50 nonintubated patients who were scheduled for a transnasal bronchoscopy. Patients either were premedicated with meperidine (Demerol, Sanofi Winthrop), 50 mg given intramuscularly, and atropine, 0.4 mg given intramuscularly, or received no premedication. Time to loss of gag reflex and any complications from the anesthesia or the procedure were noted. Immediately after the procedure, patients were asked to evaluate the taste of the topical anesthesia on a scale of 1 to 4 (1 = pleasant; 2 = mildly unpleasant; 3 = unpleasant; 4 = extremely unpleasant) and to evaluate the overall impression of the procedure on a scale of 1 to 5 (1 = not unpleasant; 2 = slightly unpleasant; 3 = unpleasant; 4 = very unpleasant; and 5 = intolerable).

In the lidocaine group, 64 percent (16/25) found the taste to be unpleasant or extremely unpleasant, in the benzocaine group, 28 percent (7/25) found the taste to be unpleasant or extremely unpleasant (p = 0.05). We found a correlation between the taste of the anesthetic and acceptance of the bronchoscopy procedure (p = 0.05). There was no significant difference in time to loss of gag reflex, and no complications were noted in either group.

In summary, we conclude that benzocaine 20% and lidocaine 4% are both effective and safe topical anesthetics. More patients in the lidocaine group found the taste to be unpleasant or extremely unpleasant, as compared with the benzocaine group. We found a significant relationship between the taste of the anesthetic and patient tolerance of the bronchoscopy procedure. Further study of the effectiveness of topical anesthesia and its impact on the overall bronchoscopy experience may be valuable. We would be interested in seeing topical anesthesia practices included in the next ACCP bronchoscopy survey.

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To the Editor:
Since 1981 I have personally performed almost 1,000 therapeutic bronoscopies using rigid and fiberoptic bronchoscopes, the CO₂ laser, the YAG laser, cautery, and photodynamic therapy. From this experience, there are some conclusions in the article by Drs Prakash and Stubbs in the December 1991 issue of CHEST that I wish to challenge.

Bronchoscopy is not performed enough, rather than too often. We repeatedly see patients with almost total obstruction of their bronchi who have normal chest x-ray films. At least two or three times a year I have to dissuade patients from seeing their physicians because they have been followed up with chest radiography and never underwent bronchoscopy. Patients with colon resections are routinely followed up with barium enemas or colonoscopy to detect early recurrence. Supine films of the abdomen are not adequate.