Communications to the Editor

Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Specific permission to publish should be cited in a covering letter or appended as a postscript.

Treatment of Atelectasis of the Right Upper Lobe with a J-shaped Catheter

To the Editor:

We read with special interest the article by Majid, which appeared in the September 1991 issue of Chest.

We developed a technique of blind selective bronchial suctioning with a curved-tipped catheter with a guide mark. With use of that technique we have both prevented and treated atelectasis of the lungs in adults and children, and bronchoscopy has not been necessary for that purpose for more than 12 years.

However, we found that our technique cannot be used for prevention and treatment of atelectasis of the right upper lobe owing to the angulation of our catheter and the angulation of the right upper lobe bronchus. Therefore, we developed a method of blind selective bronchial suctioning with a J-shaped catheter tip with a guide mark for prevention and treatment of atelectasis of the right upper lobe. With that method we treated 14 cases of atelectasis of the right upper lobe in 11 patients. Subsequently, we also successfully treated two similar cases of atelectasis by means of our method. This method has also been used to treat atelectasis of the left upper lobe. There has been no previous report of successful treatment of atelectasis of the right or left upper lobes, as in our series, using only a suction catheter.

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1 Majid AA. J-shaped catheter for endobronchial aspiration of right upper lobe bronchus during rigid bronchoscopy in pediatric patients. Chest 1991; 100:862

Galbladder Wall Thickening
A New Diagnostic Sign of Acute Pulmonary Embolism?

To the Editor:

The excellent article by Stein et al., which appeared in the September 1991 issue of Chest, describes the clinical, gasometric, roentgenographic, and electrocardiographic aspects of acute pulmonary embolism (PE) in patients without previous cardiac or pulmonary disease. The diagnosis of this life-threatening condition is most difficult even for experienced clinicians. The pathologic thickening of the gallbladder wall visualized with abdominal sonography, a significant initial sign of right-sided heart failure, may be of value in the diagnosis of acute PE. We report a case of acute PE that illustrates this sign.

A 47-year-old woman was admitted in shock. Twenty-four hours earlier vomiting, coldness, sweating, paleness, and moderate fever had begun, and there was rapid worsening of the clinical situation. She denied dyspnea and thoracic pain. One month previously hysterectomy and double oophorectomy had been performed because of a uterine leiomyoma. Clinical examination revealed hypotension (80/60 mm Hg), tachycardia (138 beats per minute), tachypnea (38 breaths per minute), and a temperature of 38°C. Poor perfusion signs were evident; there was no jugular distention. The findings from cardiopulmonary, abdominal, and neurologic examination were all normal. There were no signs of deep venous thrombosis or phlebitis in the lower extremities. Arterial gasometry revealed a PaO2 of 62 mm Hg and a PaCO2 of 21.4 mm Hg, with an alveoloarterial oxygen gradient of 61 mm Hg. The chest radiograph and electrocardiogram were normal. A septic abdominal cause, secondary to previous abdominal surgery, was suspected. A sonogram obtained immediately after surgery had been normal, but a sonogram obtained at the time of the admission for shock demonstrated marked thickening of the gallbladder wall, with a double-wall appearance, and a fluid collection within the wall (Fig 1). These findings were considered to be due to acalculus cholecystitis. Surgery was excluded because of the poor clinical condition of the patient. Right-sided cardiac catheterization demonstrated a right...