phosphorylation. Additionally, the serum lactate level was measured in one of our cases early in the hospital course, and it was found to be normal. We believe that if uncoupling of oxidative phosphorylation were primarily responsible for shock and multiple-system organ failure, the serum lactate level should have been markedly elevated.

Dr Schmidt correctly points out that the elevations in tumor necrosis factor and interleukin-6 noted in our patients may be epiphenomena. Although cytokines could have contributed to our patients’ illnesses, the data reported in our article are merely observational, and no conclusions can be drawn regarding the role of cytokines in causing hypotension and organ failure in salicylate intoxication. Unless an animal model can be developed, it is unlikely that the pathophysiology of this apparently uncommon syndrome will be unraveled.

From a clinical standpoint, we would like to reemphasize the point made by Dr Schmidt in his letter, namely, that there is a differential diagnosis of hyperdynamic shock that includes disorders other than sepsis and that for several of these disorders (eg, beriberi, adrenal insufficiency, and salicylate intoxication), specific therapy with thiamine, corticosteroids, or dialysis may significantly affect patient outcome.

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REFERENCES

Dysphagia as a Complication of Oral Anticoagulation Therapy

To the Editor:

Several manifestations in the upper airway have been reported among the different complications of oral anticoagulant therapy.\(^4\)\(^5\) We have not found any reference to dysphagia as an adverse effect of this kind of drug,\(^4\) although we have found reports of other unusual side effects.\(^4\)\(^5\)

We present the case of a 45-year-old woman with a history of mitral stenosis, open commissurotomy, and paroxysmal atrial fibrillation, who was on warfarin therapy with acenocoumarol, digoxin, chlorthalidone, amiodarone, and oral potassium. She came to the emergency service of our hospital because of progressive dysphagia, anorexia, fatigue, and pain when she opened her mouth. Physical examination revealed paleness of the skin, a small hematoma on her tongue, and another hematoma in the pillars of the fauces. There was a soft tumor in the maxillary and submaxillary region, as well as hematomas of different sizes in the abdominal wall and lower extremities.

The hemoglobin level was 10.6 g/L; the international normalized ratio (INR) was 7.2; the platelet count was 175,000\(\mu\)/L; and the partial thromboplastin time was 233 s. Macrosopic hematuria was noted. Abdominal ultrasonography and computed tomography showed retroperitoneal hematoma.

The patient was admitted into the hospital, and received two units of fresh plasma. Aacenocoumarol was discontinued. On the fifth day, the INR was normal, and hematuria was absent. The patient’s outcome was satisfactory.

We conclude that dysphagia may be a side effect of anticoagulant therapy.

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3 Monreal M. Hemorragias en el tratamiento con anticoagulantes orales. Med Clin (Barc) 1990; 94:212-14

Asthma and Work

To the Editor:

In the December 1991 issue of Chest, Dr Rosenman\(^1\)\(^2\) discusses asthma and work. There is much discussion about asthma outside the work environment and “for years after leaving work.” The word allergen is used, but not once are the terms allergens and allergic (atopic) patient mentioned. Why were these types of patients not properly investigated for atopy (allergy)?

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1 Rosenman KD. Asthma and work: how do you diagnose the association? [editorial]. Chest 1991; 100:1481-92

To the Editor:

Dr Cohen, an allergist, expresses concern that my editorial did not address investigating the patient for atopy. I assume by that he meant applying skin tests and/or using radioallergosorbent testing (RAST) for common allergens.

If I had mentioned testing for sensitization to common allergens, it would have been to state that such testing is not very useful in confirming or negating the association between asthma and work. This is because of the high prevalence of positive skin tests to common allergens among asymptomatic people in the general population (20 percent),\(^1\)\(^2\) the absence of an association between atopy and asthma for low-molecular-weight chemicals such as isocyanates,\(^4\)\(^5\) the poor predictive value of these tests for determining who will have work-related asthma from exposure to high-

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