Major Hemorrhage as a Complication of Cough Fracture

To the Editor:

Violent or sustained coughing may result in rib fracture. Serious complications of cough fractures are very rare, and major bleeding has not, to our knowledge, been previously reported.

A grossly obese 61-year-old man was admitted to the hospital with a severe asthmatic attack and coughing. On admission, a bruise was noted on the left side of the epigastrium, and there were symptoms and clinical signs of left-sided rib fractures. Rib fractures were confirmed by radiography, which also showed moderate pleural fluid on the left side. Gradually the patient developed subcutaneous emphysema, and the bruise became a major subcutaneous hematoma (Fig 1). A rupture of an intercostal artery was suspected. Coagulation tests were normal, and there were no signs of hematologic disease. With blood transfusions and supportive treatment, the patient recovered completely.

Stefan Hjalmarsson, M.D., Trygvi Asmundsson, M.D., Jon Sigurdsson, M.D., Bjarni Torfason, M.D., and Gudmundur S. Jonsson, M.D., Landspitalinn National University Hospital, Reykjavik, Iceland

Reprint requests: Dr. Asmundsson, Landspitalinn, National University Hospital, Department of Medicine, 101 Reykjavik, Iceland

REFERENCES


Upper Airway Obstruction Following Angiotensin-converting Enzyme Inhibitor Therapy

To the Editor:

We read with great interest the explanation for angiotensin-converting enzyme inhibitor (ACEI)-induced angioedema proposed by Jain et al1 in the September 1992 issue of Chest. Marked obesity, prior face and neck surgery, and prior endotracheal intubation were implicated as factors that might predispose patients who take these agents to symptomatic upper airway obstruction. The observations of Jain et al might be rejected by some clinicians because of the small number of patients in the study. To further support their analysis of risk factors, we offer the demographic data on eight additional patients treated for ACEI-induced angioedema at our institution during the past 3 years (Table 1).

Future attention to the variables cited by Jain et al will be required to validate their postulate, but it appears to be helpful in identifying the patients whom we have treated. Especially important is the role of marked obesity, a condition that also increases the risk of systemic hypertension that requires pharmacologic antihypertensive intervention.

Thomas M. Roy, M.D., F.C.C.P., Ryland P. Byrd, Jr., M.D., and Cheryl L. Fields, M.D., Division of Respiratory Medicine, University of Louisville School of Medicine, Louisville, Kentucky

REFERENCE

Table 1—Data on Eight Patients Treated for ACEI-induced Angioedema With Upper Airway Obstruction

<table>
<thead>
<tr>
<th>Patient/Age, yr/Sex</th>
<th>Height, cm</th>
<th>Weight, kg</th>
<th>% Ideal Body Weight</th>
<th>Previous Intubation</th>
<th>Previous Head/Neck Surgery</th>
<th>Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/55/M</td>
<td>178</td>
<td>143</td>
<td>190</td>
<td>Yes</td>
<td>No</td>
<td>Enalapril</td>
</tr>
<tr>
<td>2/75/F</td>
<td>150</td>
<td>59</td>
<td>130</td>
<td>Yes</td>
<td>Yes*</td>
<td>Enalapril</td>
</tr>
<tr>
<td>3/76/F</td>
<td>158</td>
<td>77</td>
<td>146</td>
<td>Yes</td>
<td>No</td>
<td>Enalapril</td>
</tr>
<tr>
<td>4/49/M</td>
<td>183</td>
<td>81</td>
<td>164</td>
<td>No</td>
<td>No</td>
<td>Enalapril</td>
</tr>
<tr>
<td>5/41/F</td>
<td>160</td>
<td>76</td>
<td>138</td>
<td>Yes</td>
<td>No</td>
<td>Enalapril</td>
</tr>
<tr>
<td>6/52/M</td>
<td>185</td>
<td>93</td>
<td>111</td>
<td>Yes</td>
<td>No</td>
<td>Captopril</td>
</tr>
<tr>
<td>7/64/M</td>
<td>173</td>
<td>75</td>
<td>107</td>
<td>No</td>
<td>No</td>
<td>Enalapril</td>
</tr>
<tr>
<td>8/83/M</td>
<td>183</td>
<td>77</td>
<td>96</td>
<td>Yes</td>
<td>No</td>
<td>Lisinopril</td>
</tr>
</tbody>
</table>

*Carotid endarterectomy.

To the Editor:

As noted by Roy et al, our initial report (1) was speculative, in that a small number of patients were analyzed for possible risk factors for upper airway obstruction complicating ACEI use. Nonetheless, we thought that our observations were of sufficient interest to signal other clinicians in the hope of confirming these possible factors. Accordingly, we find the similar findings summarized by Roy et al to be of interest and believe they add credence to our earlier observations. The confirmation of a relatively rare clinical event requires awareness and recognition by the medical community at large. We hope that these reports will bring these potential risk factors to the attention of a wider audience, and that as a result their reality will be clearly determined.

Manu Jain, M.D.,
Lora Armstrong, R.PH., and
Jesse B. Hall, M.D.,
Department of Medicine,
Pritzker School of Medicine of the University of Chicago,
Chicago

Critical Care Board Examination Resources

To the Editor:

The purpose of this letter is to outline my preparation for the exam and the resources I found most useful in time for those readers who are preparing for the 1993 ABIM CCM Board.1 There was a variety of textbooks I consulted in the year of studying for the exam, but the one I purchased and used most frequently was Rippe’s, Critical Care Medicine.1 I found it well written, and it’s chapters coincided with the content areas outlined by the ABIM for the CCM exam.

A major resource of my review was provided by the Society of Critical Care Medicine (SCCM). Especially instructive for me were the two question and answer tests published by the SCCM, as I would do each section, grade myself with the annotated answers, and go back and reread the ones I got wrong and figure out why.2,3 I had several other sources of questions including books by Cane et al,2 Sahn and Heffner,4 Hall et al,4 and even some Medical Knowledge Self-Assessment Program Pulmonary and Critical Care questions.4 One final resource for questions was the yearly SCCM-sponsored exam at the annual meeting.5,6 In retrospect, this was a very productive area, since it pointed out deficiencies or areas where I needed some work.

Another resource was the American College of Chest Physician’s, Pulmonary and Critical Care Update.7,8 With its text followed by questions and eventually receiving the answers, I was able to cover some excellent territory.

When work schedules allowed, I attended review courses, beginning with a local SCCM review, continuing with the Critical Care Medicine Review and Update Course offered by Dr. Joe Parrillo and colleagues in Maryland, the two board review courses held in Chicago, and also the SCCM annual meeting. I enjoyed all the courses and found them especially good venues to approach noted speakers or researchers in the field after their talk and get some “personal tutoring” in the form of explaining some difficult topic covered. These exchanges were invaluable.

Fortunately, I had not tossed any of my Critical Care Medicine or Chest journals, so I began the task of rebrowsing through them to pull out the articles I needed to study and learn from. I also checked my file cabinet of articles and began reacquainting myself with the major works in the field of CCM. I began to appreciate this body of knowledge.

I recited CCM topic material into a cassette recorder and listened to the tapes as I jogged. I enjoyed this as a study tool so much that I expanded this practice and proceeded to dictate anything I was confused about. I approached it as if I were teaching someone, and the maxi about having to master a subject prior to teaching it is true. This was very helpful.

I found studying for the exam a grueling but interesting experience, one made more palatable by my girlfriend’s (now my wife) support, as well as the fun of learning. It was an experience I will never forget.

Len Scarpinato, D.O.
St. Mary’s Hospital
Milwaukee

REFERENCES
9 Dellinger RP, Taylor RW, Davis WR, eds. Critical care self-assessment program. XI. Fullerton, Calif: Society of Critical Care Medicine, 1990