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.

Delayed Perforation of the Esophagus by a Closed Thoracostomy Tube

To the Editor:

I recently read the article by Oz M. Shapira et al entitled “Delayed Perforation of the Esophagus by a Closed Thoracostomy Tube,” which appeared in the December 1993 issue of Chest.1

The authors claimed they were reporting on a previously undocumented complication of a trocar free thoracostomy tube and further stated that they were unable to find any previous reports on perforation of a normal esophagus by thoracostomy tube.

In 1980, my colleagues and I at the University College Hospital, Ibadan, Nigeria, reported the case of a 4½-year-old child with perforation of normal esophagus caused by chest intubation (without trocar) for empyema thoracis. The case was reported in the Journal of the National Medical Association.2 This journal is published in the United States.

I would therefore like to state that their case was not the first to be reported in the English literature as claimed by the authors.

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REFERENCES

A Nearly Fatal Tracheal Obstruction Resulting From a Transtracheal Oxygen Catheter

To the Editor:

I read with interest the report by de Groot et al.3 “A Nearly Fatal Tracheal Obstruction Resulting From a Transtracheal Oxygen Catheter,” in the November issue of Chest. The authors postulated that this complication has not been reported before with the use of the ITO2C (Johnson, Cook; Bloomington, Ind) transtracheal oxygen catheter. Their colleagues3 from the Groningen University Hospital, the Netherlands, however, have previously reported in this Journal this complication using the same device.

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REFERENCES
2. van der Werf TS, Meinesz AF, Postmus PE. Airway obstruction by a mucus ball from a transtracheal oxygen catheter. Chest 1982; 101:1739-40

Interpreting Peritonitis and Septic Shock Investigation Data

To the Editor:

The recent article by Desai et al4 in the October 1993 issue of Chest concerning intramuscular Pco2 measured in an animal

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