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

To The Editor:

I would like to thank Dr. Samuel A. Adebonojo for his comments. We apologize that our extensive literature search before writing our case report (Chest 104:1897-98) did not include his article. Our case had some significant differences compared with the patient reported by Dr. Adebonojo. Our patient was treated in a medical hospital with possibly different stands of care from the Nigerian hospital that he reported from. In addition, the patient that we cared for was an adult patient without any of the confounding issues that were presented by Dr. Adebonojo’s case report (J Natl Med Assoc 1980;72:315-18). His patient was a 4½-year-old child, who was being treated for a known empyema with a chest tube and was clinically malnourished. The confounding factors—malnutrition, presence of infection, possible mediastinitis or irritation of the esophagus from chest tube, and a possible size mismatch of the tube to the child—accentuated the predisposition of the esophagus to such injury.

Our patient was a healthy adult being treated for a traumatic injury in which no predisposing factors for esophageal perforation were present. The only explanation for the injury that occurred in our patient was esophageal perforation secondary to a malposition chest tube. Our treatment was also somewhat different from that which was extended to the Nigerian patient and that reflected in the differences in the availability of resources.

We again want to thank Dr. Adebonojo for bringing his important contribution to our attention.

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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.1 “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 colleagues2 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 1992; 101:1739-40

Interpreting Peritonitis and Septic Shock Investigation Data

To the Editor:

The recent article by Desai et al1 in the October 1993 issue of Chest concerning intramusosal Pco2 measured in an animal...