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. Please include a cover letter with a complete list of authors (including full first and last names and highest degree), corresponding author’s address, phone number, fax number, and e-mail address (if applicable). Specific permission to publish should be cited in the cover letter or appended as a postscript. CHEST reserves the right to edit letters for length and clarity.

Resecting Pulmonary Cancer of a Colorectal Origin

To the Editor:

We are interested in the article written by our Dutch colleagues, van Halteren and coworkers, (June 1995)1 entitled “Pulmonary Resection for Metastases of Colorectal Origin.” The limited number of patients known to be resected for colorectal metastases of the lung amazes us. We can remember several cases in our hospital alone. Our pathologist (R.A.J.V) searched the Pathologisch Anatomisch Landelijk Geautomatiseerd Archief database for cases from the 5 hospitals in our region (4% of all hospital beds in the Netherlands). He found at least eight proven cases of resection for metastases of colorectal cancer. We doubt therefore whether, as was stated, all patients operated on for this particular condition have been included. If not, a considerable number has been missed because of inadequate research in the Pathologisch Anatomisch Landelijk Geautomatiseerd Archief. Despite the above, we support the conclusion that patients with three or fewer pulmonary metastases of colorectal origin may benefit from resection.

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Blunt Cardiac Injury

To the Editor:

Drs. Feghali and Prisant (December 1995)1 present a review of the incidence, diagnosis, and management of blunt myocardial injury. This review, however, includes information that is both incomplete and incorrect and serves to confuse rather than clarify the management of patients with this injury.

The phrase, “blunt myocardial injury,” itself is misleading as are similar phrases such as “cardiac contusion” and “cardiac concussion.” This spectrum of injury is more properly called “blunt cardiac injury.”

In describing the mechanism of injury, the authors note that a combination of impact against the steering wheel followed by sudden deceleration as the initiating event. However, most authors would separate the mechanism of injury into either direct compression against the sternum or between the sternum and the vertebral column resulting from a direct blow, as in a steering wheel injury, or sudden deceleration occurring in either the vertical or transverse directions, as well as increases in intrathoracic pressure by transmission across the diaphragm.

In describing the spectrum of injuries, the authors neglect to mention coronary artery thrombosis that has been well described in association with blunt cardiac injury. The authors additionally compare blunt cardiac injury to myocardial infarction but fail to describe that the pathophysiology of these two processes is entirely different. Myocardial infarction occurs as a result of inadequate perfusion, most often on the basis of coronary artery thrombosis, and it occurs in the distribution of the affected vessel. Blunt cardiac injury, however, is a well-localized phenomenon with local ischemia only.

The authors have reviewed the literature regarding the management of patients with this diagnosis who require emergent surgical intervention and note that patients have low complication and mortality rates. They recommend invasive intraoperative monitoring, but neither the patients who would benefit from this nor the appropriate intraoperative monitoring is identified.

For clinicians dealing frequently with patients who have potential for blunt cardiac injury, the history and clinical presentation are of utmost significance. In trauma patients, the mechanism of injury is of great importance and is a necessary part of the history. Despite the authors’ assertions, sinus tachycardia is the most common dysrhythmia seen in patients with cardiac injury (as it is in all trauma patients). The occurrence of dysrhythmia within the first 4 to 6 h after injury is of the greatest prognostic significance in determining the patients who will have complications.

Despite the wide recognition among trauma practitioners of the lack of utility of creatine kinase (CK-MB) isoenzymes in establishing this diagnosis,2,3 the authors recommend their use in recognizing blunt cardiac injury. The authors state that CK-MB is often elevated in the trauma patient and has a marked lack of sensitivity and specificity for establishing the diagnosis. The authors, however, recommend the use of CK-MB levels to make the diagnosis of the blunt cardiac injury. Additionally, they recommend 24 h of cardiac monitoring with accompanying ECG and CK-MB determinations. These endorsements are not supported in the literature, as it has been determined, by several large series, that patients who have normal ECG monitoring for 4 to 6 h can be safely discharged from the hospital.4,5 Additionally, the monitoring of CK-MB levels in this group of patients is only to be condemned as not being helpful to the management of the patients, being potentially confusing, and generating extra costs. To quote Maddox et al,5