infarction in 1992, status post percutaneous transluminal coronary angioplasty in 1992, mitral regurgitation, aortic stenosis, peptic ulcer disease, gallstones, and gastroesophageal reflux. He consumed a 6 pack of beer each day and had a 120 pack-year smoking history.

Previous therapies aimed at stopping the hiccups included dilatation of an esophageal stricture, cisapride, lansoprazole, chlorpromazine, compazine, and irritating the pharynx with a small catheter through the nose. None were effective.

We treated his hiccups with 3 cm³ of 4% topical lidocaine nebulized in a standard small-particle nebulizer. With the first treatment, he experienced significant relief of his hiccups such that he was able to sleep soundly. He used 1 treatment per day for 3 days with complete resolution of his hiccups until 3 weeks after the last nebulized lidocaine treatment when hiccups recurred. At that time, hiccups were less severe than before and again responded to nebulized lidocaine.

We suggest that nebulized lidocaine should be considered in the treatment of intractable hiccups, perhaps even before oral medications are tried. The only side effect of nebulized lidocaine is a short-term loss of the gag reflex. Our patient was instructed to avoid eating or drinking 30 min before and 2 h after treatments to decrease the risk of aspiration. We were reluctant to have him try gargling with the lidocaine for fear of aspiration during a hiccup.

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REFERENCES
1 Rousseau P. Hiccups. South Med J 1995; 88:175-81
5 Sanders RV, Kirkpatrick MB. Prolonged suppression of cough after inhalation of lidocaine in a patient with sarcoid. JAMA 1984; 252:2456-57

Risks of Home Oxygen Therapy for Cigarette Smokers

To the Editor:

Home oxygen therapy is known to prolong survival in patients with COPD who have hypoxemia (Po₂ <55 mm Hg). Even though the potential hazards of home oxygen therapy are well known and it is standard practice to warn patients of these dangers when initiating therapy at home, there are 10 to 20% of patients receiving long-term oxygen therapy who probably continue to smoke.1,2

A review of the medical literature revealed rare reports of accidents that ranged from burns on the face to death from carbon monoxide poisoning after the bed linen and the oxygen cylinder were ignited.6 Despite the higher than expected frequency of smoking in patients who are receiving long-term therapy, the report of complications is relatively rare. The reasons for this maybe that (1) patients receiving oxygen therapy are cautious while smoking by disconnecting the oxygen connection or removing the nasal cannula while smoking, (2) that complications are under reported, or (3) that indeed oxygen therapy maybe relatively safe in patients who continue to smoke. In this report, we describe an unusual complication of a patient who was receiving home oxygen therapy and who continued to smoke.

A 60-year-old man with idiopathic pulmonary fibrosis required continuous nasal oxygen therapy. On one occasion, he was smoking in his bedroom while receiving oxygen when the nasal cannula, tubing, and connections caught fire. He was able to remove the cannula from his face without suffering from any burns, but his bed sheet, blanket, and carpet caught fire. Soon his house was on fire but he managed to escape with minimal minor injuries. Fortunately, there was no one else at home, and except for significant property damage, no one else was injured. This is the only report of major property damage due to smoking while a patient was receiving oxygen therapy.

There is no general consensus about prescribing oxygen therapy for patients who smoke, so there remains a variability in prescribing oxygen therapy to these patients. It is clear from this report that in addition to personal physical harm there is a potential danger to others in the surrounding areas. Following this incident and the other reports in the medical literature,3-6 it is our belief that the risks outweigh the benefits in prescribing oxygen therapy for patients who continue to smoke. In conclusion, we recommend that oxygen therapy should not be prescribed to patients who continue to smoke.

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REFERENCES
4 Knox GW, Frable MAS. Smoking and oxygen a lethal mix. Va Med Q 1986; 113:431

Erratum

In the article “Determinants of Aerosolized Albuterol Delivery to Mechanically Ventilated Infants” by Coleman, Kelly, and McWilliams (CHEST 1996; 109:1607-13), there was a mistake in the abstract. The AeroChamber and AeroVent devices are manufactured by Monaghan Medical Corporation in Plattsburgh, NY. Monaghan Medical is not associated with the ACE adapter device, which is manufactured by Diemolding Healthcare Division in Canastota, NY.