Sedation in Fiberoptic Bronchoscopy

To the Editor:

We read with interest the recent study by Maltais and colleagues1 concerning the use of oral lorazepam as sedation for fiberoptic bronchoscopy. We were disappointed that the authors did not take note of a recently published study comparing IV midazolam versus IV phenoperidine/droperidol combination vs placebo in patients undergoing diagnostic fiberoptic bronchoscopy but not diagnostic lavage.2 In this study, opiate sedation conferred no advantage over placebo in patient perception of comfort, but reduced willingness to have a repeat bronchoscopy, a finding attributed to the dysphoric effects of the opiate. The midazolam regimen, although making the procedure easier for the bronchoscopist (as determined by visual analogue scale) was not significantly better than the placebo sedation for patient comfort or willingness to have the procedure repeated.

The study by Maltais and colleagues1 is important in highlighting that an oral premedication, with its ease of administration and no requirement for venous access, is a useful alternative. However, some caution must be urged as patients receiving minor tranquillizers are known to be at an increased risk of automobile accidents.3 Benzodiazepines, particularly in the elderly, have also been shown to decrease daytime performance4 and increase the risks of hip fracture.5

If sedation is to be used during bronchoscopy, parenteral administration of short-acting benzodiazepine makes the procedure easier for the doctor while allowing the depth of sedation to be controlled and providing venous access.6 Although such issues are important, one must not lose sight that the patient should be involved in whether they wish to have sedation, especially as it confers little advantage over placebo. From personal experience we find that many patients prefer to have no sedation and be allowed to drive home after the procedure.

5 Wayne RA, Griffin MR, Downey W. Benzodiazepines of long and short elimination half-life and risk of hip fracture. JAMA 1989; 262:3303-07

Advanced Pulmonary Histiocytosis X Is Associated With Severe Pulmonary Hypertension

To the Editor:

Histiocytosis X (HX) is a rare disease that can involve destruction of the lung parenchyma, due to the proliferation of Langerhans’ cells in the airway spaces. Lesions present an almost entirely peribronchial distribution, and therefore, the disease could be considered a bronchiolitis.

On the basis of radiologic CT findings of increased size of the pulmonary arteries, some reports have suggested the presence of pulmonary hypertension (PH) (Fig 1).1,2 In 1950, Cunningham and Parkinson3 described the obstruction of vascular lumina due to the proliferation of Langerhans’ cells in some cases of lung HX with PH. This observation, however, has never been confirmed by extensive hemodynamic studies, to our knowledge.

From 1986 to December 1995, 21 patients with advanced pulmonary involvement due to HX were addressed to our institutions for lung or heart and lung transplantation. A histologic diagnosis was available in 15 cases, while in two patients, radiologic features consistent with the presence of bone eosinophilic granuloma were present. In two more patients, an elevation of CD1a-positive cells (more than 5%) on bronchoalveolar lavage strongly supported this diagnosis, while in the remaining two patients, a clinicoroadiologic diagnosis was accepted. Pulmonary function tests (PFTs) and hemodynamic data are reported in Table 1.

Twenty of 21 patients presented a certain degree of PH, 12 a severe degree (mean pulmonary artery pressure >50 mm Hg). The level of PH was not related to the impairment of PFTs, in particular to hypoxia. Actuarial survival at 50 months was 35% and none of the PFT or hemodynamic data resulted in prognostic factors. Moreover, a similar degree of PH was not observed in patients with lymphangioleiomyomatosis (n=8) or pulmonary fibrosis (n=43) evaluated for lung transplantation.