A 47-year-old woman referred to us in 1993 bearing an invasive lymphoepithelial thymoma stage III according to Masaoka classification. Four chemotherapy courses with ADOC scheme were administered in association with oral prednisone (25 mg/d without any interruption between cycles), and a partial response was obtained. She underwent surgical resection of the residual mass and became disease free. Two further ADOC cycles have been administered afterwards. One year later a chest CT scan showed a pleural recurrence not suitable for radical resection. The patient was submitted to a salvage treatment with paclitaxel (175 mg/m²) associated to cyclophosphamide IV (600 mg/m²) administered every 21 days in association with corticosteroid therapy. At first, when restaging after three cycles, no tumor reduction has been observed. She was then treated with epirubicin (Farmorubicina; Pharmacia; Milano, Italy), 100 mg/m², IV bolus injection every 21 days, associated with oral lonidamine (Doridamina; Angelini ACRAF; Rome, Italy), 450 mg/d. No corticosteroids were assumed. This three-line treatment was stopped after 5 cycles because the patient reached the maximal tolerable dose of anthracyclines. A CT scan, performed at the end of the treatment showed a ~90% reduction of the tumor mass. This result was confirmed by a further CT scan 2 months later.

Due to the substantial unresponsiveness to the conventional second-line approaches, patients with advanced thymoma previously treated with ADOC scheme are candidates for new drug treatments. In the case described here, however, paclitaxel administered in association with cyclophosphamide and corticosteroids failed to be active. Conversely, a long-term partial remission has been obtained with epirubicin associated with lonidamine, a derivate of indazole-3-carboxylic acid, which is able to selectively interfere with the energy metabolism of neoplastic cells. This may be the mechanism by which lonidamine is able to circumvent multidrug resistance to chemotherapy through alteration of membrane permeability and/or inhibition of the drug efflux pump stimulated by the multi-drug resistance/P (MDR/P) glycoprotein. The potentiating effect of anthracycline activity by lonidamine has been repeatedly demonstrated in vitro and in a recent Italian multicentre phase III trial involving advanced breast cancer patients.

To conclude, it is our opinion that epirubicin plus lonidamine scheme should be further tested as second-line treatment in patients progressing to ADOC and other anthracycline plus cisplatin-containing regimens.

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REFERENCES

Sampling Arterial Blood With a Fine Needle

To the Editor:

Radial arterial puncture for obtaining blood samples is a painful procedure that justifies the use of prior local anesthesia in the puncture area to significantly reduce pain.1 Providing local anesthesia, however, supposes piercing twice, once for anesthetic infiltration and once again for arterial puncture. Some authors2 have suggested that performing the puncture with a smaller diameter needle would reduce pain, making anesthesia unnecessary and at the same time shortening the procedure.

We compared pain intensity produced by radial arterial puncture in 60 patients, using the conventional anesthetic infiltration technique3 with mepivacaine through a 27.5-gauge needle followed by puncture with a 22-gauge needle (QS 90; Radiometer Medical A/S; Brønshøj, Denmark), or puncturing directly with a 25-gauge needle without prior anesthesia. The patients were assigned randomly to two groups of 30 to undergo puncture with or without anesthesia; there were no differences of age, sex, or prior arterial puncture between the two groups. Pain was quantified on a visual analog scale of 10 cm (0, complete absence of pain; 10, maximum pain).

Mean (+SD) pain levels reported were 1.9 (+1.1) cm (range, 0 to 3 cm) for the conventional technique and 2.8 (+1.3) cm (range, 0.6 to 5.3 cm) (p=0.004) for direct puncture with a 25-gauge needle. The procedure took a mean 158 (+12) s using the conventional technique and a mean 122 (+13) s with the 25-gauge needle (p<0.001). The conventional procedure, with anesthetic infiltration, costs about 25 cents more.

The use of the narrow 25-gauge needle does not make the procedure more difficult, and it takes less time and reduces cost. However, the pain caused by puncture is at times fairly intense, greater than with anesthesia and quite similar to that observed with placebo.1 We therefore believe that, as only anesthetic infiltration guarantees that arterial blood samples can be obtained with tolerable pain for patients, this extra step should be taken, in spite of the savings in time and money that can be achieved by using the finer gauge needle without anesthesia.

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REFERENCES

The Role of Intermittent Enteral Feeding in Reducing Gastric Colonization in Mechanically Ventilated Patients

To the Editor:

We read with interest the recent article, "Intermittent enteral feeding in mechanically ventilated patients: the effect on gastric pH

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Communications to the Editor

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