To the Editor:

We have not published "virtually the same data twice." As stated in the introduction to our paper, the objective was to look at the safety of drugs other than inhaled β-agonists. No previous study had done this. For all drugs, crude rate ratio estimates fell progressively when adjusted for an increasing number of potential confounding variables; this fact illustrates that controlling for severity is essential in exploring risk or safety in retrospective studies of asthma. Our study also showed that it is only possible to exclude confounding if one has access to a substantial number of well-defined severity markers. These two conclusions stand irrespective of population and outcome selection.

We address the issue of intermediate causal pathways toward the end of the "Discussion" section of our paper.

The concerns raised by Pearce and colleagues are not new and some have been addressed by us in another letter.1

Harold H. Rea, MD
Jeffrey E. Garrett, MBChB
John Kolbe, MBBS
Respiratory Services
Green Lane Hospital
Auckland, New Zealand
Stephan Lanes, PhD
Epidemiology Resource Inc.
Newton Lower Falls, Massachusetts

REFERENCE

Hoarseness in Schistosomal Cor Pulmonale

To the Editor:

Here we report the case of a patient with schistosomal cor pulmonale who presented with cardiocaval (Ortner's) syndrome and hoarseness due to aneurysmal dilatation of the main pulmonary artery and its major branches. The patient was a 27-year-old man, an ex-smoker for 2½ years. He had been treated three times with praziquantel for both urinary and intestinal schistosomiasis. He presented with exertional dyspnea, was easily fatigued, and had a slowly progressive hoarseness of voice of 2 months' duration.

Conventional radiographs revealed aneurysmal dilatation of the main pulmonary artery and its branches, and cardiomegaly of right ventricular (RV) configuration. Indirect laryngoscopy revealed complete left vocal cord paralysis. Computed tomography revealed normal lung parenchyma with no focal lesions. The main pulmonary conus as well as its main central branches were enlarged. However, they were normally opacified with injected contrast medium and showed no evidence of intraluminal thrombosis. Small focal calcific spots were seen at the left margin of the main pulmonary trunk. The other mediastinal vascular structures (namely, the aorta and its branches) as well as the superior vena cava were normal in size and course. The heart was rather enlarged, with evidence of RV enlargement. The trachea, the main stem bronchi, and their lobar and segmental divisions were normal. There was no evidence of mediastinal or hilar nodal enlargement, nor were there pleural collections or detectable lesions in the chest wall. Scans through the upper abdomen showed moderate splenic enlargement with no focal splenic or hepatic lesions. Pulsed-wave Doppler echocardiography revealed severe pulmonary hypertension with an acceleration time of 67 ms (mean pulmonary artery pressure, 49 mm Hg). The interventricular septum moved paradoxically. The right ventricle was markedly dilated and hypertrophied with severe tricuspid and severe pulmonary regurgitations. The left ventricular diameters were normal.

Cardiovocal syndrome has also been described in patients with mitral stenosis, atrial septal defects, ventricular septal defects, and aneurysms of the ascending and descending aorta.2 A case of reported pseudoaneurysm of the aortic arch with the patient complaining of chest pain and hoarseness has been described.2 Atrial myxoma elevating the left main stem bronchus and left pulmonary artery into the concavity of the aortic arch has been narrated.3 Also described was a 9-month-old infant with a double outlet of the RV, pulmonary arterial hypertension, and a hoarse cry that returned to normal after surgery.4 Anecdotal reports of hoarseness in a patient with primary pulmonary hypertension and another with patent ductus arteriosus were also thought to be due to greatly dilated pulmonary arteries compressing left recurrent laryngeal nerves.5

In summary, we present a case of cardiovocal syndrome due to aneurysmal dilatation of the pulmonary artery and its major branches in a patient with schistosomal cor pulmonale.

M. Salah El Din Sorour Soliman, MD
Alexandria University
Alexandria, Egypt

REFERENCES

Difficulties With Fiberoptic Bronchoscopic Cryotherapy

To the Editor:

We read with great interest the article entitled “Fiberoptic Bronchoscopic Cryotherapy in the Management of Tracheobronchial Obstruction” (September 1996).1 In our clinic, we had a chance to work with instruments similar to those described: ERBE E20416-11(13) [ERBE USA Inc; Marietta, GA] flexible cryoprobes, with diameter of 2.2 (2.4) mm and length of 90 cm, each connected to Erbokryo CA (ERBE USA Inc) with CO₂ freezing agent. The cryoprobes were used with an Olympus IT20D bronchoscope and an Olympus video-set (Olympus America; Melville, NY) so that all manipulations were video-recorded.

We treated only five patients with very good results, but we had some problems. Because we used the same method as Mathur et al1 (same premedication, local anesthesia, outpatient operation and control), we think that the authors might have had the same difficulties.