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 email 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.

Management of Asthma

Applied Knowledge is Power

To the Editor:

I am writing in reference to the update of Drs. Hanania and Guntupalli on the “Management of asthma: a global perspective,”1 and to Dr. Marino’s letter, essentially on the same subject (September 1996).2 As a member of the Brazilian Consensus on the Management of Asthma in 1994,3 a position earned from many years of active work in this area, I feel that lines of reasoning such as those of Dr. Marino should be considered, and would benefit from the contributions of colleagues around the world. I strongly endorse Dr. Marino’s point that knowledge (about asthma) becomes power only if translated into action. The complexities observed in this approach in the Northern Hemisphere are becoming apparent. In the developing countries, they will certainly prove insurmountable. In our area, it is utterly impossible to ascertain the true magnitude of nonadherence, which has been estimated by indirect evidence to amount to at least 17% of patients.4 Patient education in underprivileged areas will prove impossible, particularly when the Brazilian Federal Health Plan pays US$2.00 per visit, and the private plans pay US$8.50. On the other hand, in happier times, we found that the short-term failure rate of asthma therapy, measured by clinical and sociological parameters, fell from 40% to 30% because of a protocol to investigate possible factors responsible for these failures. Since nothing else was changed, we concluded that this fall in failure rate had to be attributed to the placebo effect caused by closer attention to the patient. Could this mean that we should simply optimize the physician-patient relationship, without shackling it with rigid and probably utopic rules? Nontabulated data from a Balint-type therapeutic experience showed some surprising results.5 Will the action for which Dr. Marino calls come more easily through feeling and empathy rather than through knowledge?

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Anesthetic Cream for Arterial Cannulation

To the Editor:

I read with great interest the article of Giner et al1 (December 1996) on pain during arterial puncture. The authors have inferred from their clinical trial that an arterial puncture without analgesia is more painful than a venous puncture. This makes the use of a local anesthetic mandatory before arterial cannulation. One of the reasons for avoiding local anesthetic infiltration for such procedures is the difficulty in locating an artery after an infiltration, especially in obese patients or those with a low volume pulse.

I have found EMLA cream (Astra USA, Inc; Westboro, Mass.); a eutectic mixture of lidocaine and prilocaine, useful for arterial cannulations. Application of 1 to 1.5 g of this local anesthetic cream over the cannulation site (which is then covered with a semi-occlusive dressing for 45 min) gives excellent dermal analgesia for at least 1 h, and the analgesic effects last for 2 to 5 h. This makes the whole procedure painless, even if multiple punctures are needed.

EMLA cream is well tolerated and the side effects (local reactions) are transient and clinically insignificant. The cream has been used for alleviation of pain associated with intravenous cannulations,2 skin biopsies,3 and even pediatric renal biopsies.4

I would strongly recommend the regular use of EMLA cream before an arterial cannulation.

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REFERENCES

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