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Bronchial Arterial Infusion for Lung Cancer

To The Editor:

Osaki and colleagues (May 1999)1 have recently reported their experience with bronchial arterial infusion (BAI) of chemotherapy in centrally located early stage lung cancer. They report prolonged disease-free survival in six of seven patients treated in this manner, with one patient dying of massive hemoptysis 3 months after BAI. While this is an interesting pilot study, there are a number of questions raised by this report, mainly related to patient selection. Four patients had a single carcinoma in situ lesion (stage 0), while the remaining three patients had a carcinoma in situ lesion in addition to a latter stage carcinoma (T2, T3, or T4). All isolated carcinoma in situ lesions seem to have been diagnosed on sputum cytology alone. It is not clear in the report whether those with isolated in situ lesions were symptomatic or whether the cytology was done as part of a screening program for high-risk individuals. No mention is made of bronchial biopsies, and it is therefore assumed that the diagnosis was made on cytology alone. Most would agree that this pathologic diagnosis is difficult to make on cytology alone and usually requires bronchial biopsy.2

A beneficial effect of BAI on survival cannot be assumed from this pilot study. In the first instance, all invasive carcinomas were managed by appropriate surgical resection. Secondly, the prognosis of carcinoma in situ lesions of the bronchus is generally very good. The finding of carcinoma in situ at the bronchial margin after resection for bronchogenic carcinoma has been shown to have no adverse effect on survival, suggesting an inherently good prognosis for in situ lesions.3–5 Future studies of BAI would therefore require inclusion of patients other than those with stage 0 disease.

Patients with carcinoma in situ may not require active therapeutic intervention, given the absence of any adverse impact on survival when this pathology is present.

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What To Do When Bloody Fluid Is Obtained on Pericardiocentesis?

To the Editor:

The excellent article from the Mayo Clinic group,1 in which Tsang et al reviewed their 19 years of experience with echocardiographically (echo-) guided pericardiocentesis, proves that echocardiography is useful not only for diagnosis of pericardial effusion but also for management of pericardiocentesis. These authors concluded that echo-guided pericardiocentesis is simple, safe, and effective for primary treatment of clinically significant pericardial effusion.

The authors mentioned that, when bloody fluid was encountered during the procedure, agitated saline contrast material should be injected to confirm the position of the needle. There is a simpler and faster method to determine if the pericardiocentesis needle is in the pericardial space or in the intracardiac chamber, when echocardiography is not readily available, especially in emergency situations.

For the past 45 years, I have always included an ampule of dehydrocholate and an ampule of lobeline on the sterile pericardiocentesis tray.2–3 If blood or bloody fluid is obtained on pericardiocentesis, dehydrocholate, or lobeline in the case of an obtunded patient, should be injected through the aspirating needle. If the patient gives a typical response, as in an ordinary circulation time determination, the needle is in a cardiac chamber, when echocardiography is not readily available, especially in emergency situations.

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