Communications to the Editor

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). An electronic version of the communication should be included on a 3.5-inch diskette. 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.

Supranormal Expiratory Flow Rates in Patients With Interstitial Lung Disease

To the Editor:

I wondered, in assessing the likelihood of interstitial lung disease in their patient, whether Wagers et al (February 2000)1 might comment on the following: (1) What is the usefulness of the high expiratory flow rates—FEV1/FVC ratio of 0.89, 119% of predicted—as a noninvasive index of increased retracile forces in the lung, a point not commonly adverted to in standard references. Gold2 stated, “Thus, in early interstitial lung disease, even before lung volumes are decreased, the flow-volume curve usually shows supranormal expiratory airflow.” (2) Please comment also on the utility of correcting the carbon monoxide diffusing capacity of the lung for alveolar volume in distinguishing between interstitial lung disease and other causes of reduction in the alveolar volume. It is my recollection that this has not been found to be as discriminating as hoped. (3) What is the meaning of the term height-to-rate ratio? Was “height-to-weight ratio” intended?

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REFERENCES

To the Editor:

We would like to thank Dr. Jerome Reich for his interest and comments on our article. The FEV1/FVC ratio has been taught to all of us in medical school as showing a “restrictive pattern” when it is normal or above normal. This is no doubt in part due to statements such as the one you quote, found in many seminal references on pulmonary function testing. A recent article by Aaron et al3 reported the positive predicted value of a low FVC and a normal or above-normal FEV1/FVC ratio to be only 58% for the determination restriction, as confirmed by lung volumes necessitating the measurement of total lung capacity (TLC) when a restrictive pattern is found. This was the pattern seen in our patient. These authors concluded that spirometry is good at ruling out a restrictive defect, as < 3% of those with a normal vital capacity in their study subsequently were shown to have restrictive defect by TLC measurement; in those with a low vital capacity and a restrictive pattern, measurement of a TLC is necessary.

As to the second comment, we agree; perhaps we should have emphasized this point more in our article. For further elaboration, see the American Thoracic Society guides on single-breath diffusing capacity. Lastly, you are correct. It should read “height-to-weight ratio.” We would also like to point out that the legend on Figure 4 reads “as percentage of predicted TLC,” and it should read “percentage of TLC.”

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REFERENCE

Cardiac Tamponade Following Acupuncture

To the Editor:

I read with interest the recent case report of cardiac tamponade following acupuncture by Kirchgatterer et al (May 2000).1 According to these authors, only three other similar case reports were found in the literature.2–4 I wish to call their attention to another three case reports that preceded the three they cited.

The first case report of cardiac tamponade following acupuncture was by Schiff5 from Miami, FL, and was published in 1965. The subject, an 82-year-old Hungarian emigre, was found dead in her home by a relative. According to her next-of-kin, she was known to have practiced acupuncture for chronic angina. At autopsy, the acupuncture needle point was found to have penetrated the anterior surface of the heart for a distance of 1/8 inch, producing a wide laceration of the distal branches of the left anterior descending coronary artery close to the apex. The pericardial cavity was filled with 250 mL of partially clotted blood. The anterior pericardial surface showed petechial hemor-