Acute Stroke Trial found that aspirin reduced the incidence of cations. Both the International Stroke Trial and the Chinese noncardioembolic ischemic stroke who do not have contraindications, is recommended (grade 1A by the American College of aspirin is widespread in these patients and, based on extensive data, is recommended (grade 1A by the American College of Chest Physicians) as secondary prophylaxis for all patients with noncardioembolic ischemic stroke who do not have contraindications. Both the International Stroke Trial and the Chinese Acute Stroke Trial found that aspirin reduced the incidence of recurrent stroke but not of pulmonary embolism. We believe that aspirin plus an anticoagulant prophylactic agent should be used in these patients if there are no contraindications.

Correspondence to: William H. Geerts, MD, FCCP
Sunnybrook and Women’s College Health Sciences Centre
Toronto, ON

REFERENCES
5 Harenberg J, Schonhauer U, Flosbach CW. Enoxaparin is superior to unfractionated heparin in the prevention of thromboembolic events in medical patients at increased thromboembolic risk [abstract]. Blood 1999; 94(suppl):390a

O物件ide in the Treatment of Chylothorax

To the Editor

We read with interest the article by Demos et al in the March 2001 issue of CHEST. We would like to make two comments, and we would like to share our experience with octreotide administration in one of our patients suffering chylothorax.

First, significant reduction of chest drainage had already occurred after the initiation of total parenteral nutrition (TPN) and before administration of octreotide. The doxycycline infusion (with the resulting clot in the tube and the necessity of a second tube thoracocentesis) may have altered the evolution of chest drainage. It is difficult to evaluate the results of treatment with octreotide, which was started 2 days after the insertion of the new tube. Additionally, the thoracentesis of 500 mL fluid on 28th day after insertion of the tube proved the existence of loculated effusion. It is possible that some amounts of chyle continued to accumulate in other, smaller loculated spaces, although the tube had stopped its drainage. This possibility creates further difficulties for interpreting the consequences of octreotide treatment. The addition of intrapleural doxycycline and its results (clots, new tube insertion, thoracentesis) complicated the evolution of drainage and the correct evaluation of octreotide administration.

Second, which treatment is more effective—somatostatin or octreotide? Successful treatment of chylothorax with somatostatin was mentioned first in 1990 and was been confirmed in another report. Octreotide is a somatostatin analog and offers the advantage of subcutaneous administration, while somatostatin demands continuous IV infusion.

The authors of the above-mentioned article reported that chylothorax in a 4-month-old boy had been treated successfully with octreotide. We read this article by Rimensberg et al, and we did not find any report of octreotide. Rather, Rimensberg et al reported the administration of somatostatin as a continuous infusion.

Because of the advantage of subcutaneous administration, we decided to administer octreotide (Sandostatin; Novartis AG; Basel, Switzerland) to one of our patients with chylothorax after a left pneumonectomy. A 52-yr-old man was admitted to our hospital for squamous cell carcinoma in the left lung. He underwent left pneumonectomy with lymph node dissection. On the second day, we noticed an increased drainage of serous liquid in the chest tube (1200 mL) [Fig 1]. On the third day, the patient had a light lunch, and the liquid became milky. The biochemical examination confirmed the diagnosis of chylothorax (triglycerides, 150 mg/dL; total cholesterol, 110 mg/dL).

Cessation of oral intake and TPN started immediately. The drainage was reduced dramatically in 3 days (from 2150 mL/24 h to 350 mL/24 h) [Fig 1]. On the sixth day, the drainage was 350 mL. On the seventh day, we started subcutaneous administration of octreotide (100 μg bid for the first 2 days and 100 μg tid for the next 6 days), but there was no reduction in the amount of drainage. An aggressive treatment is suggested if chest drainage is >200 mL/24 h (as occurs in conjunction with video-assisted thoracoscopic surgery or open surgery). However, in our case, we decided to continue the conservative treatment because, although some amount of fluid is normally expected, we had faced a chylothorax after pneumonectomy where the hemithorax was completely empty. On the 15th day, we stopped octreotide administration, and on the 20th day, the chest tube was removed when drainage dropped to 250 mL. We continued the TPN for 4 days (24th day), and on the 23rd day, we started enteral nutrition by a feeding tube with a solution containing medium-chain triglycerides. Daily radiographs revealed normal evolution.
of the air-liquid level. On the 29th day, the feeding tube was removed, and the patient started oral intake. No complications occurred, and the patient was discharged the 33rd day. He has remained well for 4 months, to the time of this writing.

In our opinion, octreotide did not help our patient. Before reading the article by Demos and colleagues, we had found one other report on effective administration of octreotide (administered after thoracoscopic ligation of the thoracic duct) and one report of noneffective subcutaneous administration of octreotide.

Our case demonstrates another incidence of noneffective octreotide administration. However, Cheung et al reported on two infants who developed chylothorax after surgery for congenital heart disease and who were treated successfully with subcutaneous octreotide.

It is known that somatostatin reduces intestinal absorption of fats and intestinal blood flow and motility. Thus, administration of somatostatin, simultaneously with TPN, is a therapeutic option for treatment of chylothorax and could reduce the need for surgical intervention. However, the administration of octreotide instead of somatostatin is questionable, as there are two noneffective cases (that described in Stefanidis et al and our own case reported here) and three cases with good results.

We agree with Drs. Demos, Kozel, and Scerbo that effectiveness of octreotide cannot be proven or established by our case reports and that further confirmation is necessary to establish or reject the role of therapy in the chylothorax treatment.

Dimitrios Mikroulis, MD  
Vassilios Didili, MD  
Grigorios Bitzikas, MD  
Georgios Bougioukas, MD  
General Hospital of Alexandroupolis  
Alexandroupolis, Greece

Correspondence to: Dimitrios Mikroulis, MD, Cardiothoracic Dept, General Hospital of Alexandroupolis, 19, Dimitras St, Alexandroupolis, PC 681 00 Greece; e-mail: dmikrou@med.duth.gr

REFERENCES


To the Editor:

First, I agree with the authors’ reservation with drawing iron-clad conclusions from our first adult case. That is the reason I welcome more application of octreotide (Sandostatin; Sandoz; East Hanover, NJ) treatment of chylothorax in adults to perhaps establish its proper place in our armamentarium.

We have used octreotide acetate in a total of five adult patients. Four patient had spontaneous chylothorax. The fifth and last patient had chylothorax on the seventh day after right lower and middle lobectomies for severe suppurating bronchiectasis with a daily milky output of 800 to 1,360 mL/d. On the second day after total parenteral nutrition and nothing orally, and octreotide, 100/mg q 8 h, the chest output, now serous, decreased to 340 mL, 150 mL, 280 mL, 280 mL, and 110 mL, respectively. The chest tubes were removed after doxycycline installation. Two more patients, one with lymphoma, responded 2 weeks and 4 days, respectively, after the initiation of octreotide treatment.

Of the five patients, one did not respond, had end-stage posthepatitic cirrhosis, and had concomitant chylous ascites and chylothorax and was treated aggressively for his liver disease. Finally, after several weeks, he recovered.

Therefore, we have had an 80% success in the treatment of chylothorax with octreotide. One more point that might be helpful is that in one patient, we had to double the dose of octreotide for 1 week to achieve arrest of the chylothorax. I hope

Figure 1. Chest drainage and serum albumin in relationship to TPN, octreotide administration, and medium chain triglycerides (MCT) enteral nutrition.
these comments are helpful in encouraging more surgeons to apply and report their experiences with octreotide.

Gene R. Pesola, MD
Jersey City, NJ

REFERENCE


Endobronchial Sarcoidosis and Hyperreactive Airways Disease

To the Editor:

We read with interest the article by Shorr et al (September 2001),1 regarding the hyperreactive airway response (AHR) seen in the subgroup of nonsmoking patients with newly diagnosed sarcoidosis and endobronchial disease. Although the data are limited,1 (Table 1) if sarcoidosis is a given, the probability of the test (endobronchial biopsy) for diagnosing sarcoidosis approaches one if the patient has AHR with no other obvious etiology for AHR. In nonsmoking subjects who present with abnormal chest radiographic findings compatible with stage I sarcoidosis, the probability of getting an endobronchial biopsy compatible with sarcoidosis is about 50% if the patient eventually is found to have sarcoidosis.2 Presumably, if the patients in that study also had AHR, the probability of making a diagnosis of sarcoidosis would increase even further, and the best way to do it might be by endobronchial biopsy if there are no external lesions to sample and the Kveim test was not available.3,4 If more data back up the claim that AHR in newly diagnosed sarcoidosis almost always guarantees a diagnosis of endobronchial sarcoid, then EBB can be added to the diagnostic approach in making a diagnosis of lung disease in subjects with nondiagnostic symptoms and other indicators suggestive of sarcoidosis.

In patients without a diagnosis with chest radiographic findings compatible with stage I sarcoidosis and AHR with no other cause, the leading diagnosis should probably be sarcoidosis until proven otherwise,5 assuming this preliminary study is correct. In this particular case scenario, the endobronchial biopsy would be of great value. We look forward to more studies validating the findings of Shorr et al.1

Gene R. Pesola, MD, MPH
Mostafa Kurdi, MD
Margaret Olbrice, MD, FCCP
Harlem Hospital/Columbia University
New York, NY

REFERENCES


Preoperative Bronchoscopic Biopsies and Staging

To the Editor:

We read with interest the article by Riedel et al (June 2001),1 who concluded that systematic multiple biopsies and brush and washing cytology are an accurate procedure in evaluating possible airway invasion by supracardinal esophageal carcinoma. We also use biopsies in our practice,2 but we are very cautious in the interpretation because we have had a lot of negative biopsy findings in patients in whom tracheobronchial invasion was evident at bronchoscopic examination. Therefore, we do not feel confident in making a clinical choice (airway infiltrated or not, that is, operate on the patient or not) based on the results of the biopsies.

Looking in depth at the data of Riedel et al,1 (Table 2) there was...