LETTERS TO THE EDITOR

Vocal cord dysfunction and wheezing

We read with interest the editorial by Drs J Goldfarb and M Muers (June 1991;46: 401-4). Although we agree with most of the review, we would disagree with their comments on hypoxaemia. They state that absence of hypoxaemia in vocal cord dysfunction helps to differentiate this condition from acute asthma.

We have seen two cases ourselves where hypoxaemia is a feature of vocal cord dysfunction. In one case the hypoxaemia (arterial oxygen tension $(P_aO_2)$ 79 mm Hg with 100% inspired oxygen) and the induced ‘wheeze’ were immediately relieved by intubation without recourse to assisted ventilation. On another occasion a similar effect was produced by the administration of a small dose of anaesthetic.

Nolan et al 1989 report four patients, three of whom had demonstrable hypoxaemia during an acute episode $(P_aO_2$, 8-45, 5-18, and 6-1 kPa respectively). Appelblatt et al 1981 report three patients who had hypoxaemia during an acute attack $(P_aO_2$, 50, 52, and 44 mm Hg). Finally, in the report by Christopher et al 1983 cited in the editorial the alveolar-arterial oxygen tension gradient was reported as normal in all five patients yet two young and apparently otherwise fit subjects had a $P_aO_2$ below 70 mm Hg.

We conclude that the comments regarding hypoxaemia are inaccurate and may lead to inappropriate management. As the authors point out, failure to make the correct diagnosis could result in potentially harmful iatrogenic complications.

Thus in our experience and that of other authors the presence of abnormal blood gases does not exclude a diagnosis of vocal cord dysfunction. We would however support the second summary conclusion that any acute attack should be treated as asthma unless or until there is objective evidence to the contrary.

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AUTHORS’ REPLY

We wish to thank Drs Niven and Pickering for their interest in our paper. We consider that our views on patients with vocal cord dysfunction and wheezing are in fact quite similar. There is no doubt that hypoxaemia can occur in association with this syndrome, but we believe this to be the exception and not the rule. We did in fact state that hypoxaemia had occurred in the patients of Appelblatt et al (their reference 3). We still believe that the absence of hypoxaemia is usually helpful in differentiating vocal cord dysfunction from acute severe asthma. The presence of hypoxaemia does not, however, exclude vocal cord dysfunction. When faced with a wheezing hypoxic paediatric patient we feel it safest to recommend treatment for asthma and subsequently present with hypoxaemia may be confident enough to “administer a small dose of anaesthetic” but we believe that this advice cannot be given in an editorial to those less familiar with the condition. We stand by our statement that hypoxaemia is a useful indication that asthma is likely to be genuine, although perhaps “in nearly all patients” might be added in anticipation of Dr Niven and colleague’s case report.

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BOOK NOTICE


In the foreword to this wonderful book we are reminded that “Tobacco kills worldwide more than 2.5 million people prematurely every year. This is an appalling, almost unimaginable toll of suffering and death, representing a waste of human resources which ought to be unacceptable in a civilised society.” The authors of this book then go on to enthuse, inform, and encourage their readers in the struggle against tobacco. They are remarkably successful in this aim. Most of the book is taken up by 10 “case studies” of initiatives, policies, and the shaped recent smoking control history. The topics include the enormously influential compilation of statistics of smoking related diseases in the United Kingdom called The Big Kill, with the numbers of affected individuals broken down according to individual health authorities and parliamentary constituencies, and the shameful episode of Shol Bandits (when the Government subsidised a new tobacco factory in Scotland, built by US Tobacco to manufacture oral tobacco snuff). Some of the case histories are an inspiration—for example, the Victorian Tobacco Act—and others rather depressing—for example, the voluntary agreement between the tobacco industry and the Government. Throughout this book there is much good advice on how this can be achieved, and the letters and contact addresses of all the key individuals involved, and the organisations are listed. There is also an enormously useful book list. This book is written with an authority that reflects the direct experience and commitment of the authors working in the field of tobacco control. In my view it should be required reading for anyone interested in combating smoking.—J.M

CORRECTIONS

Carboxyhaemoglobin in women exposed to different cooking fuels

In the paper by Dr D Behera and others (May 1991;46:344-6), on page 344 in line 13 of the abstract, 7-9% should be 7-49%, and on page 345 in line 10 of “Results” $(p = 0.03)$ should appear after “users.”

Prevalence of asthma among 12 year old children in New South Wales: a comparative survey

In the paper by Dr DMJ Barry and others (June 1991;46:405-9) on page 407, column 1, line 17, 3% should be 31%. 

REFERENCE

Intercostal arteriovenous fistula due to pleural biopsy.

J B Howell

Thorax 1991 46: 688
doi: 10.1136/thx.46.9.688-b