

our current diagnostic imaging world than we would initially suspect. His discovery of "magnetic sleep"-induced clairvoyance—the ability to visualize their internal organs and those of others—in the two hysterical Okey sisters in 1838 has been expanded and researched in a scientific manner by Shealy and Myss (2) in 1988.

C. Norman Shealy, MD, PhD, a Harvard-trained neurosurgeon and inventor of the dorsal column stimulator and the transcutaneous electrical nerve stimulation (TENS) device, has been collaborating since 1985 with Carolyn M. Myss, MA, Catholic theologian, publisher, and intuitive diagnostician in an effort to provide a scientific basis for this low-tech "magnetic imaging" technique. In their book, they present the results of a simple but dramatic research project involving 50 patients evaluated in a blinded fashion. Myss was in New England and was given only the name and birthdate of the patients over the phone by Shealy, who was in Missouri, and was asked to make an intuitive medical diagnosis specifying organ involvement and disease process for comparison with the medical diagnosis known only to Shealy. By using her special abilities, she was able to obtain clairvoyant images of the patients and make a specific and accurate diagnosis in 93% of the cases.

In the past few years, Shealy and Myss have expanded their experience to several hundred patients with similar success. There are certainly numerous criticisms of this research that can be provided by skeptics, and it is important that such claims be subjected to the same rigorous evaluation expected of other clinical studies. However, in this era of cost-containment with recent harsh criticism of overutilized, expensive digital imaging technology, it may be worthwhile to evaluate inexpensive alternative "magnetic imaging" techniques that make use of an underutilized priceless resource—our own biocomputers.

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■ Use of Furosemide in Patients with Syndrome of Inappropriate Antidiuretic Hormone Secretion

From:

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Editor:

A recent case report by Bhargava and Lewandowski in the September 1991 issue of *Radiology* (1) described a 72-year-old woman who developed water intoxication as a result of the syndrome of inappropriate antidiuretic hormone secretion (SIADH) after aggressive hydration. The authors suggested endovaginal or endorectal sonography as alternative methods for studying these patients. These techniques, however, particularly endorectal sonography, are somewhat invasive, may be refused by postmenopausal patients who thus far comprise the group of patients reported to develop this complication, and may not provide the required diagnostic information (2).

The diuretic furosemide could be used instead. Furosemide inhibits reabsorption of free water, may inhibit the effect of antidiuretic hormone on the kidneys, and has been used in the treatment of SIADH. Decaux et al (3) noted that, while thiazides increase sodium excretion, thus worsening SIADH (as in one case cited by Bhargava and Lewandowski), the loop diuretics, including furosemide, do not.

Furosemide is simple to administer. To our knowledge, it has not been reported to cause any major complications after administration of a single dose except in patients who are dehy-

drated or otherwise hemodynamically unstable. It is administered routinely during nuclear renal scanning, and no complications have been reported during its use in the assessment of ureteral obstruction (4) and fetal hydronephrosis (5), or in the guidance of renal puncture (6). Nonradiologic uses for diagnostic purposes include the evaluation of hypertension (7). It has been used experimentally in humans to provoke pancreatic secretion (8) without significant untoward events other than orthostatic hypotension noted in only one patient out of more than 200 (a woman weighing 47 kg who was orally administered 60 mg) (7). In these reports (4-8), up to 60 mg of furosemide was administered orally and up to 40 mg was administered intravenously.

Therefore, oral administration of 20-40 mg of furosemide should be considered for patients with excess free water. This should precipitate diuresis, and may be considered as a safe means to facilitate bladder distension in all patients, including those predisposed to SIADH.

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■ Residency Matching Program Ethics

From:

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Editor:

As the radiology residency interviewing season begins, it is difficult to suppress the temptation to approach this time-consuming task with cynicism at our small, community hospital program. For each of the last 3 years, we have had candidates matched to us renege on the match agreement and take an unfilled position elsewhere. In each case, the candidate opted for a university department program. However, since, theoretically, an irresponsible candidate could as easily sidestep a university agreement, I do not wish to dwell on program type. One candidate, having reviewed the National Residency Matching Program rules with his attorney, was told that "there is nothing here that you cannot get out of." I believe that the decisions made by these candidates are unethical and am relieved that these individuals are not in our residency program.

Before making a plea for general fairness in the matching program, I wish to make a brief case for the legitimacy of our specific program on the basis of results alone. All of our residents pass the board examinations. Our residents have presented papers at scientific sessions of the Radiological Society of North America, Association of University Radiologists, American Institute of Ultrasound in Medicine, and American Roentgen Ray Society, at the International Electronics Imaging