paper. However, the rates represent reality in the best Philadelphia hospitals during the era of 1961 to 1965. It is possible for bias to have crept into the data if reporting of the cases by the hospital pathologists was incomplete, but I have no reason to suspect that this was so. I suspect that the rates are now lower as a result of better case selection stimulated by the sad experiences of the past, as well as by the advent of mediastinoscopy and fiberoptic bronchoscopy.

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Frequency of the Lung as the Sole Organ of Metastasis

To the Editor:

We have read with great interest the report by Ishihara et al concerning pulmonary metastasis, yet must take exception to their interpretation of the work of Farrell.2 Ishihara et al state: “The incidence of pulmonary metastasis among malignant tumors with a fatal outcome was reported by Willis3 to be 30 percent. According to Farrell2 [sic], in half of this 30 percent only the lungs are involved by such metastasis.”

In a hypothetic series of 200 necropsies on malignant cases, one would predict, according to Willis,3 30 percent, or 60 cases, to exhibit pulmonary metastases. On this much we agree. Using the Ishihara et al interpretation of Farrell2 however, one might further calculate 30 cases (“half of this 30 percent”) to have metastasis limited to the lungs. Yet Farrell2 states quite clearly that in his series of 78 cases of pulmonary metastases seen at necropsy, only 12 cases, or 15 percent, had metastasis limited to the lungs. Therefore, of the 60 cases with pulmonary metastasis in our hypothetic series of 200, there would be only nine cases, not 30, with metastasis limited to the lungs.

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Ventricular Aneurysm in Sarcoidosis

To the Editor:

Direct myocardial involvement occurs in 13 to 20 percent of cases of sarcoidosis. Usually cardiac lesions are focal and scattered and affect mostly the septum and ventricular free wall.1 Occasionally, extension and confluence occur; and in exceptional cases, ventricular aneurysm results. To our knowledge, only four such aneurysms in sarcoid heart disease have been reported.1-5

CASE REPORT

A 49-year-old black woman had 20 episodes of ventricular tachycardia between September 1969 and November 1972. These occurred despite large doses and various combinations of antiarrhythmic agents. Serial electrocardiograms showed evolution of pathologic Q waves in leads 3 and aVF. Persistent hepatosplenomegaly led in May 1972 to a liver biopsy and later a scalene-node biopsy. Both were compatible with sarcoidosis. The findings from acid-fast organism and fungal studies were negative. Right and left heart catheterizations, a left ventriculogram, and coronary arteriograms performed in July 1972 showed normal coronary arteries and right and left ventricular end-diastolic pressures of 10 and 15 mm Hg, respectively. The left ventriculogram showed akinesia of the posterior wall segment near the valve ring and moderate mitral regurgitation. The patient died in November 1972 from ventricular fibrillation.

At autopsy, mesenteric, para-aortic, hilar, and mediastinal nodes were enlarged, and hepatosplenomegaly and cardiomegaly were present. Minimal coronary atherosclerosis was present. The myocardium was extensively infiltrated by whitish scar. The posterior left ventricular wall showed aneurysmal dilatation 4 cm in diameter (Fig 1). The myocardium contained numerous areas of focal and confluent fibrosis predominantly in the left ventricular free wall. In the wall of the aneurysm, the myocardium was completely replaced by dense fibrous tissue. There were noncaseating granulomata in
REFERENCES


Correction

To the Editor:

After receiving the reprints of our article entitled "Pulmonary Function Studies in Ex-Heroin Users" (Chest 67:331-334, 1975), it was brought to my attention that there was an error on page 331 in the last paragraph of "Materials and Methods"; the last sentence should read "Predicted normal value for compliance is 0.00343 \((\text{Ht in cm})^{-0.425} \pm 0.035\)."

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