Tuberculous Lymphadenitis and Therapy with Corticosteroids

To the Editor:

I read with interest the article by Byrd and associates entitled "Surgical Complications of Cervical and Mediastinal Tuberculotic Adenitis in an Infant." Byrd et al advocated surgical intervention to relieve mediastinal compression caused by tuberculous adenitis. No mention was made of the value of therapy with adrenocorticosteroids in this condition. Adjunctive use of corticosteroids has long been advocated by Thorton and others for the treatment of hilar and mediastinal tuberculous adenitis in children. Corticosteroids are thought to reduce the inflammatory reaction.

I was interested to note that the material from biopsy revealed negative cultures for mycobacteria and apparently no formation of an abscess. I would think that the addition of adjunctive therapy with corticosteroids early in the patient's treatment might have obviated the need for later surgical intervention.

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REFERENCES

To the Editor:

We appreciate the suggestion of Farrell that therapy with corticosteroids might have been of value in our patient with tuberculous lymphadenitis. Unfortunately, as noted by a statement on adrenal corticosteroids and tuberculosis by the Committee on Therapy of the American Thoracic Society, the evidence is controversial as to the value of therapy with corticosteroids in patients with lymphatic tuberculosis. To our knowledge, the only randomized study regarding these drugs in tuberculous lymphadenitis involved their use in patients with intrathoracic nodes producing bronchial obstruction. Although radiographic improvement was noted to occur more rapidly, as did the resolution of the endobronchial lesion, in those patients receiving corticosteroids, no patients in either group required surgery. I do not believe that one can infer from these results that therapy with corticosteroids can be necessarily expected to prevent surgical complications such as those in our patient.

It should be noted that the diseased cervical nodes in our patient rapidly abscessed, becoming fluctuant within two weeks after they first became palpable. As pointed out in the case report, the abscess was quite extensive at the time of surgery. The progression of the cervical adenitis to the formation of an abscess was so rapid that it is difficult to conceive that therapy with an anti-inflammatory agent, such as corticosteroids, would have been of benefit. Further trials to determine the possible value of therapy with corticosteroids in patients with lymphatic tuberculosis would be of obvious interest.

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Coin Lesions

To the Editor:

I am writing this letter in answer to an article entitled "The Coin Lesion Story: Update 1976: Twenty Years' Experience with Early Thoracotomy for 179 Suspected Malignant Coin Lesions" by Ray et al, which appeared in the September 1976 issue of Chest. Ray et al were rightfully proud of their excellent statistics; 19 of 27 patients with malignant pulmonary nodules have survived from 18 months to 20 years without evidence of recurrence. Also, the morbidity and mortality were unusually small, for which Ray et al should be commended.

Nevertheless, the fact that 132 other persons, otherwise not needing surgery, were required to undergo...