To the Editor:

Krutich et al fail to recognize that the case reported from our institution1 was under editorial review early in 1977, prior to publication of the article to which they refer.2 Krutich et al also demonstrate lack of careful reading when they state that "one of the sources clearly stated that five of 20 cases of endobronchial metastases were from carcinoma of the breast."3 In fact, endobronchial metastases are not what King and Castleman4 describe, but rather bronchial invasion with infiltration by the tumor. To miss this point is to miss a major point of the case report.

Regarding the point about correcting the "mistake" at the end of the article concerning metastasis to the brain from cancer of the breast, it is common knowledge that cancer of the breast metastasized to the brain with an incidence of 25 to 50 percent, third in order in the studies of the reference cited.4(1938) Krutich et al should also recognize that the same reference (different page5(1977)) states that metastasis to the brain occurred 12th in frequency at an incidence of 10 percent. Other references support a similar low incidence;6 however, the point is not to argue these opposing studies but rather to recognize (as was stated in the first line of the last paragraph of our article6(1938)) that an early unusual spread occurred here (breast to brain 18 months after diagnosis of a stage-I carcinoma of the breast in a 25-year-old woman) and that perhaps pregnancy played an influential role. It is likewise important to note that distant spread beyond normal local nodes is being recognized today with probably increasing frequency in patients treated with chemotherapy and that the incidences of metastatic sites are in a constant state of flux and may change even further.

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REFERENCES


To the Editor:

In their article entitled "Endobronchial Metastasis from Cancer of the Breast" (Chest 73:94-96, 1978), DeBeer and associates reported what they believed to be the first case of cancer of the breast that metastasized to the mucosa of a major bronchus. The purpose of the present communication is to report another such documented case.

CASE REPORT

In 1973, a 69-year-old woman underwent a course of radiation therapy (5,900 rads in seven weeks) for a fungating carcinoma of the intraductal type in the left breast. Subsequently, she underwent extended simple mastectomy with dissection of lymph nodes and received therapy with diethylstilbestrol (stilbestrol).

In 1977, the patient developed a new lesion in the left upper lobe of the lung, with mediastinal adenopathy. In November 1977, she underwent flexible fiberoptic bronchoscopic examination and cervical mediastinal exploration. A biopsy of the apical-posterior segment of the bronchus to the left upper lobe and several biopsies of right paratracheal mediastinal nodes showed an infiltrating adenocarcinoma. The histologic pattern was consistent with metastatic duct-cell carcinoma of the breast, which was confirmed by comparison of the slides with previous tissue.

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To the Editor:

In their article entitled "Endobronchial Metastasis from Cancer of the Breast" (Chest 73:94-96, 1978), DeBeer et al reported a case of cancer of the breast that was metastatic to the mucosa of a major bronchus. DeBeer et al believed that this represented a distinctly rare event.

The report by DeBeer et al prompted us to review our bronchoscopic experience in patients with cancer of the breast at Walter Reed Army Medical Center during the past three years. Sixteen patients with a history of cancer of the breast underwent bronchoscopic procedures, and endobronchial lesions were visualized in nine of these patients. Of these nine patients, seven biopsies showed a malignant neoplasm that was considered consistent with the primary tumor of the breast by our Department of Pathology. The indications for bronchoscopic procedures and the findings are summarized in Table 1.

In their discussion, DeBeer et al emphasized the importance of recognizing the potential of endobronchial metastatic cancer of the breast as a cause for a lobar infiltrate. Our experience confirms their conclusion, but we would like to further stress that bronchoscopic examination should be considered in all patients with cancer of the breast who experience the onset of new respiratory symptoms, persistent infiltrates, lobar collapse, or diffuse interstitial disease. This approach may lead to an increased diagnostic yield of endobronchial lesions.

In our review, it is also of interest that of the five
patients with diffuse interstitial pulmonary disease shown by chest x-ray film, three patients had not only endobronchial disease, but also metastatic cancer of the breast involving the lymphatic vessels, as determined by transbronchial biopsy. As in the case report of DeBeer et al, exophytic masses were seen in two of our biopsy-proven cases, while the remaining five abnormal specimens from biopsy were taken from bronchial mucosa diffusely involved by nodular lesions.

With the new advances in the treatment of cancer of the breast, the clinical and diagnostic recognition of the multiple patterns of metastatic involvement of the lung becomes increasingly important. Our experience indicates that a systematic approach to the symptoms, x-ray films, and subsequent bronchoscopic evaluation of patients with cancer of the breast will identify endobronchial metastatic cancer of the breast as an increasingly common event.

**Table 1—Bronchoscopic Findings in Patients with Cancer of the Breast**

<table>
<thead>
<tr>
<th>Indications for Bronchoscopic Procedure</th>
<th>No. of Patients</th>
<th>Endobronchial Abnormal Lesion Seen</th>
<th>Biopsy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemothysis</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Localized infiltrate</td>
<td>1</td>
<td>. . .</td>
<td></td>
</tr>
<tr>
<td>New onset of wheezing and cough</td>
<td>1</td>
<td>. . .</td>
<td></td>
</tr>
<tr>
<td>Lobar collapse</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Diffuse interstitial disease</td>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Peripheral nodule</td>
<td>3</td>
<td>. . .</td>
<td></td>
</tr>
<tr>
<td>Hilar adenopathy</td>
<td>1</td>
<td>1</td>
<td>. . .</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>9</td>
<td>7</td>
</tr>
</tbody>
</table>

*Table values are numbers of patients.

To the Editor:

In their article entitled “Endobronchial Metastasis from Cancer of the Breast” (Chest 73:94-96, 1978), DeBeer and associates comment on the rarity of endobronchial metastasis from cancer of the breast. Indeed, this metastasis must be rare for carcinoma of the breast. Peribronchial metastasis on the ipsilateral side must not be nearly so rare. I have seen three such cases in my five years of practice in thoracic surgery. The metastases do not occur endobronchially, although they produce intense cough with a great deal of bronchial edema and inflammation. Such metastases are usually diagnosed by a high index of suspicion and aggressive techniques of biopsy at mediastinoscopic examination.

Jack L. Ratliff, M.D., F.C.C.P.
Alken, SC

**Eosinophilia Caused by Rifampin**

To the Editor:

Although therapy with rifampin (rifampicin) has been considered a possible cause of eosinophilia, this has never been definitely established, as the drug is usually given in combination with isoniazid, which itself may result in eosinophilia. The present case is reported because eosinophilia that developed following treatment with antituberculous drugs regressed on stopping therapy with rifampin, despite continuation of therapy with isoniazid and streptomycin.

**Case Report**

A 62-year-old man was admitted to the hospital on Aug 9, 1977, with a four-year history of cough with expectoration of grey sputum and, over the previous six months, a loss of weight of about 9 lb (4 kg). He had been treated for pulmonary tuberculosis in 1967 and again in 1972. On both occasions the patient had defaulted from follow-up, and treatment had been limited to five months and two months, respectively.

On examination the patient was thin and unwell, with a regular pulse rate, blood pressure of 120/60 mm Hg, and scattered rhonchi throughout the chest, but no other signs of note. The hemoglobin level was 17.0 gm/100 ml, and the white blood cell count (WBC) was 8,800/cu mm (eosinophil count, 200/cu mm). A smear of sputum was negative for acid-fast and alcohol-fast bacilli. The chest x-ray film showed a soft infiltrate in both upper zones, with multiple cavities on the right.

A diagnosis of pulmonary tuberculosis was made, and treatment commenced on Aug 22, 1977, with streptomycin (0.75 gm daily), rifampin (450 mg daily), and isoniazid (300 mg daily). On a subsequent culture of sputum, there was a scanty growth of *Mycobacterium tuberculosis*. On Sept 15, the WBC was 11,700/cu mm, with an eosinophil count of 4,800/cu mm. Therapy with rifampin was replaced on Sept 19 by administration of ethambutol (800 mg daily). Therapy with streptomycin and isoniazid was continued as before. Blood cell counts over the succeeding months were as follows: on Sept 26, WBC of 10,100/cu mm and eosinophil count of...