dosis to activity and generalization of the disease seems distinct. 2
Positive tonsillar specimens were fewer than had been reported, 3 but even lower figures have been quoted. 4 These
 differences might be due to differences in selecting patients, and taking and processing biopsies. In tonsillar
 specimens, granulomas were sparsely located. Therefore, in some of our
cases they might have escaped biopsy.
Conjunctival and tonsillar biopsies are quick and painless
and suited for outpatient work. Conjunctival biopsy, possibly
combined with a tonsillar one, helps to verify sarcoidosis
histologically in a remarkably high proportion of the cases,
and is to be recommended in preference to any major
procedures.

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Survival in Bronchogenic Carcinoma

To the Editor:

Long-term survival of three patients with bronchogenic
 carcinoma complicated by superior vena caval obstruction
was reported by Nogeire et al (Chest 75:325-329, 1979).
Two patients succumbed to the disease and one had an early
reurrence. We wish to report a similar patient with an
apparent cure who presented with life-threatening symptoms
secondary to caval obstruction.

Case Report

A 39-year-old white woman with a 60 pack/year smoking
history developed the abrupt onset of facial and neck edema
in July, 1972. One month later, she became dyspneic and
presented to the emergency room where examination re-
vealed an acutely ill, semi-comatose woman with non-pitting
edema of face, eyelids, neck and arms and dilated vessels
over shoulders and forehead.

Superior venacavagram showed occlusion of the superior
vena cava and left innominate vein. Mediastinal tomograms
showed a 3 x 3 cm mass extending into the distal trachea
and right main stem bronchus. Bronchoscopy with biopsy indi-
cated undifferentiated carcinoma.

The patient received initially 3500 R to a single anterior
mediastinal field to cover the upper two-thirds of the mediast-
inum. She then received intravenous cyclophosphamide in
an unknown dose followed by oral cyclophosphamide and
corticosteroid daily. Two-and-one-half months later, tomo-
grams showed a marked regression of the mass. The repeat
films in March of 1974 were normal, as were bone scan, bone
marrow aspirate and biopsy, and liver biopsy. Cyclo-
phosphamide was changed in October 1974 to pulse therapy
given orally one week out of four and was discontinued in
June 1975.

In February, 1978 the patient was seen with increased
cough, and a chest x-ray film revealed mass densities in
the left hilum and left lower lobe which cleared with antibiotic
therapy. Repeat bronchoscopy was performed which was
totally normal as were bronchial biopsy and washings, bone
scan, CT brain scan, and liver scan. Tomograms in May 1978
were normal. In February, 1980 the patient continues to be
well and disease free, eight years after the discovery of her
cancer.

Our patient is unusual in that she has survived eight years
in spite of three prognostically poor features: (1) location
of tumor in the trachea and right main stem bronchus places
this patient in a T3 category, according to the classification
of the American Joint Committee on Cancer Staging, with
the poorest survival rate of 8 percent for five years when com-
pared to midlung location (50 percent) and lobar and main
bronchus location (25 percent). 1 (2) Undifferentiated carci-
noma has been reported to have a slightly worse prognosis
than either squamous cell or adenocarcinoma 2 and does not
respond well to chemotherapy as does small cell carcinoma.
(3) Patients with the complication of superior vena caval
obstruction do particularly poorly, with a one-year survival
rate of 1 percent, as noted by Nogeire in Chest.

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Unusual Complication during Bronchial
Brushing Through the Flexible
Fiberoptic Bronchoscope

To the Editor:

In the last few years, there have been reports of some of
the complications that may occur with the use of the fiber-
optic bronchoscope. Up to now, the incidence of these
complications has been scarce and it has been mentioned
only at the accidental appearance of pneumothorax, pneumonia,
obstruction of airways, some other minor complications
and also hemorrhage of variable severity between the rare
hemoptoic expectoration and transitory and the lethal mass-
ive hemoptysis. 1-4

We report an exceptional complication not mentioned until
now: the persistent endobronchial pierce of the brush. This
unusual accident posed remarkable initial difficulties, but it
was handled successfully due to a maneuver of which knowl-
dge can be useful in solving other similar cases.

Figure 1A shows the radiologic image of the accident
when we attempted endobronchial brushing in a 43-year-old
patient who presented signs suggestive of bronchopulmonary
carcinoma of peripheral localization. The referred complica-
tion appears at the moment that penetration of the brush

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