culture results we have observed marked loculation in spite of antibiotic therapy which required open drainage. Therefore, we feel that early indicators of potential complications such as a low pleural fluid pH are extremely helpful in guiding therapy.

In the patient with a nonloculated, nonpurulent gram-stain negative fluid and a pH in the 7.30 range, we recommend another thoracocentesis be performed in six to eight hours while the patient is receiving appropriate antibiotic coverage for the pneumonia. If the pH is stable and the pleural space is not loculated, we would not institute surgical drainage. However, if the pH has dropped substantially we choose to drain the pleural space. The pleural fluid glucose (less than 60 mg per deciliter) and the LDH (greater than 1,000 IU/L) are also helpful in this regard, but probably are not as sensitive as the pleural fluid pH.

It is important to stress that any laboratory tests must be interpreted in light of the clinical setting. This is particularly true of the patient with a parapneumonic effusion. The patient who has become afebrile with antibiotics and has nonloculated, bacteriologically negative fluid and a pH of 7.25 will likely do well with antibiotics alone. On the other hand, the patient who continues to remain febrile and shows a fall in pH on serial thoracocentesis should have chest tube drainage performed. It has been our experience that the morbidity and economic burden from chest tube insertion and drainage is far less than from a thoracotomy and additional hospitalization. Thus, we tend to institute chest tube drainage early, as once loculation occurs, the need for a thoracotomy for resolution of the empyema increases markedly.

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REFERENCES


Adenovirus Type 21 in a Civilian

To the Editor:

Our case report, "Diffuse Pneumonitis Due to Adenovirus Type 21 in a Civilian," appeared in the July 1980 issue of Chest. Subsequent to the acceptance of the manuscript, Hierholzer et al.1 described an intermediate strain of adenovirus (20/H21 + 35) which was identified as adenovirus 21 by serum-neutralization tests and as types 21 and 35 by hemagglutination-inhibition tests. Adenovirus 35 is a candidate adenovirus strain currently under review by the World Health Organization.

The publication by Hierholzer et al prompted us to seek confirmation of the identity of our isolate in their laboratory. It now appears that our isolate more closely resembles adenovirus 35 than adenovirus 21, although it behaved atypically for an adenovirus 35 (ie, antiserum to adenovirus 21 reacted by serum-neutralization [titer ≥10] and by hemagglutination-inhibition [titer 20-80]). Type 35 was not suspected earlier because the published report detailing its reactions had shown only low level hemagglutination inhibition reactivity and no serum-neutralization activity with adenovirus 21 antisera.2

We regret the confusion caused by the incorrect identification of our isolate. The recent description of intermediate strains of adenovirus (21/H21 + 35) and our adenovirus 35 isolate, which cross reacts with type 21 antisera, illustrate the complexities inherent in adenovirus serotyping. It is possible that some adenovirus isolates reported as type 21 prior to the description of type 35 were intermediate strains or were adenovirus type 35 strains which cross-reacted with type 21 antisera.

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REFERENCES


Computerized Tomography in the Assessment of a Posterior Mediastinal Tumor

To the Editor:

In their recent article, Weinberg et al (Chest 1980; 77:...