To the Editor:

We agree with Dr. Colp that patient symptoms are an inexact estimate of disease severity in sarcoidosis. However, pulmonary function testing and chest roentgenograms are also imprecise measures of the disease. We have no intention of overemphasizing the patient’s symptoms in making therapeutic decisions; however, we do feel that careful assessment of patient performance through interview provides important information to the clinician which, coupled with pulmonary function data and x-ray films, aids in management.

Dr. Colp misinterprets our paper in referring to the authors’ statement that “the Dco never worsens after the chest x-ray film clears ...” None of the ten patients with untreated stage II or III sarcoidosis and spontaneous radiographic clearing referenced in our Table 4 had a ≥ 20 percent reduction in Dco during sequential testing. Indeed, Table 6 shows a 20 percent or greater fall in Dco in only one of 26 patients with radiographic improvement of parenchymal sarcoidosis during corticosteroid therapy. We emphasized the infrequency of this sequence in concluding that less than 5 percent of patients with roentgenographic improvement of parenchymal sarcoidosis will exhibit a coincident reduction in either vital capacity or Dco. Dr. Colp refers to the report of Sharma, Colp and Williams as supporting her contention that in “untreated patients undergoing spontaneous healing, the tendency is for the Dco to decrease slightly with time as the x-ray film clears ...” The referenced experience is really not disparate with our conclusion. Their untreated group consisted of 28 patients with sarcoidosis, only four of whom had stage II or III disease and spontaneous improvement on chest x-ray film. The majority of patients in the untreated group had stage I disease or stage II or III without radiographic improvement. Using a 20 percent variation in Dco as significant (the same standard utilized in our review), none of their four patients with stage II or III sarcoidosis and spontaneous x-ray film improvement had a decrease in Dco. Two patients increased their Dco > 20 percent, one had an 11 percent increase, and one patient exhibited a 17 percent decrease.

Richard H. Winterbauer, M.D., F.C.C.P., and
John F. Hutchinson, M.D.
Division of Respiratory Disease
The Mason Clinic, Seattle

Pseudo-pseudo Tumor of the Lung

To the Editor:

The article by Fanta and colleagues (Chest 1980; 78: 346-348) prompts me to comment on a patient we treated. Our patient, a 55-year-old Italian immigrant with carcinoma of the left upper lobe, was found on x-ray examination to have a rounded, egg-shaped mass on the right diaphragm. Pneumoperitoneum suggested the mass to be contiguous with the liver. This was confirmed by a nuclear scan, sparing the patient bilateral thoracotomy, or even worse, denying him pneumonectomy on the left side. The nuclear scan was so characteristic that the surgery was not delayed, to the patient’s benefit, with eight years survival, free of recurrence.

Richard J. Lescoc, M.D., F.C.C.P.
Torrance, California

Right Middle Lobe Aspiration Pneumonia following Gasoline Siphonage

Signs of the Times

To the Editor:

Over the past three years we have had three patients present with right middle lobe aspiration pneumonia occurring after attempts to siphon gasoline from motor vehicles. The following report is typical.

CASE REPORT

This 18-year-old woman was admitted with right-sided pleuritic pain and productive cough two days after having inhaled gasoline she was siphoning from a car. She had also swallowed some of the gasoline which she vomited. Her admission temperature was 100.4°F (38.0°C) with fine moist rales heard anteriorly over the right midlung field. PA and lateral chest roentgenograms showed a right middle lobe consolidation without loss of volume (Fig 1). The white blood cell count was 14,000, with 46 polys and 25 bands. The patient was treated with IPPB, analgesics and erythromycin with good response and was discharged three days after admission.

DISCUSSION

While much has been written on aspiration pneumonia and hydrocarbon pneumonitis, the specific nature in which the right middle lobe is involved in our cases is considered rather unique. Hydrocarbons elicit very little cough reflex and are therefore easy substances for direct aspiration, either diffusely or into the lower lobes. In order to selectively fill the middle lobe, the patient would have to be bent forward in exactly the position assumed on siphoning gasoline. The only other patient in our files with selective

Figure 1. A PA view of the chest shows a right middle lobe consolidation with obscuration of the right heart border.