to the problem. The studies shown in Table 2 examined the incidence of tuberculosis among patients who have undergone partial gastrectomy. The duration of follow-up after surgery (when reported) varied from 1 to 16 years, and the incidence of tuberculosis varied from 0.4 to 5.0 percent. Most authors concluded that the incidence of tuberculosis among patients who have undergone gastrectomy is higher than the incidence in the general population in that area, but, again, data from matched control groups are lacking in most reports.

One of the better designed studies is that of Thorn and associates. They followed 749 patients (616 men and 133 women) who had undergone a partial gastrectomy for peptic ulcer and who had normal chest x-ray film findings before surgery. The follow-up period ranged from 1 1/2 to 6 1/4 years. Fourteen of the 616 men developed tuberculosis during the follow-up period. The annual incidence of tuberculosis among these men was about five times the rate for men of the same age in the area. These authors also found that the annual incidence of tuberculosis was three times higher among men who had had a gastric ulcer than among those who had a duodenal ulcer alone. Those with "high" ulcers had the highest incidence. Low preoperative weight also seemed to predispose to subsequent pulmonary tuberculosis. Those who were less than 85 percent of their ideal body weight before operation were about 14 times more likely to develop pulmonary tuberculosis than those whose weight was normal (± 15 percent of ideal) for their height.

Hanngren and Reizenstein studied 48 clinical parameters among 38 patients with tuberculosis and 317 patients without tuberculosis who had been subjected to gastrectomy because of a gastric or duodenal ulcer. These investigators found that severe dumping was more common among patients with tuberculosis who had undergone gastrectomy than among those without tuberculosis, thus suggesting that patients who have undergone gastrectomy and who suffer from malnutrition secondary to intestinal malabsorption are at greatest risk of tuberculosis.

A high proportion of patients who have undergone partial gastrectomy have been men over 40 years of age. Many are alcoholics, and many have had a low weight/height ratio. These latter characteristics might be responsible for the apparent increased risk of tuberculosis rather than the gastrectomy per se.

In summary, the evidence that gastrectomy predisposes to tuberculosis is highly suggestive but not conclusive. The previously observed higher risk of tuberculosis among patients who have undergone gastrectomy may be due to other characteristics of this population, rather than due to the gastrectomy per se; however, pragmatically, this distinction may not make much difference. Regardless of the reason(s) for the increased risk of tuberculosis, patients who have undergone gastrectomy, especially those with low weight/height ratios or with malabsorption syndromes, would appear to be legitimate candidates for preventive therapy.

Dixie E. Snider, Jr., M.D., M.P.H., F.C.C.P.
Atlanta

Chief, Research and Development Branch, Division of Tuberculosis Control, Center for Prevention Services, Centers for Disease Control.

Reprint requests: Dr. Snider, CDC-CPS, 1600 Clifton Road, NE, Atlanta, Georgia 30333

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Gallium-67 Scintigraphy for Preoperative Evaluation of The Mediastinum in Lung Cancer Patients

Gallium-67 (Ga) scintigraphy of the thorax has been used in the preoperative diagnostic evaluation of lung cancer patients since the middle of the last decade, and a large number of comparative evaluations have been published. Gallium-67 accumulates nonspecifically in various lung lesions ranging from neoplasms to various inflammations. In some neoplasms, enhanced uptake of Ga by the tumors permits scintigraphic detection of sites involved by either the primary tumor and/or metastases. Since Ga scintigraphy is a noninvasive procedure with virtually no morbidity, this test was proposed as a "tumor-finding" technique which could contribute in the preoperative evaluation and staging of patients with primary lung carcinoma.

Two general algorithms for the use of Ga thoracic scintigraphy evolved: one proposed bypassing staging mediastinoscopy if the Ga study showed a gallium-avid primary tumor but no evidence of focal gallium accumulation within the mediastinum; ie, no lymph nodes with detectable metastatic disease; the other algorithm proposed using the Ga scan as a guide for lymph node biopsy during mediastinoscopy. These concepts were based upon either accepting the high sensitivity value for Ga scintigraphy as presented in...
several papers or by concern about the low specificity values for the \(^{67}\)Ga scans noted in a number of published reports.

A serious problem in most studies which evaluated the accuracy of mediastinal \(^{67}\)Ga scintigraphy is how was the presence or absence of metastatic disease in the lymph nodes determined? It is very difficult to obtain tissue diagnoses for both positive and negative sites when one evaluates any imaging technique. Thus, much of the evaluation and comparative literature of diagnostic imaging is structured upon the rather weak foundations of “correlation with other radiographic studies,” “clinical follow-up,” and similar generalizations based at best upon a single biopsy or often even less histologic data for determination of “truth.” Rarely is an imaging technique evaluated with a site-by-site analysis of positive and negative findings confirmed by surgeons willing to biopsy or resect all tissue sites under study.

In this issue (see page 428), the article by McKenna et al, presents a much needed evaluation based upon data obtained in 75 patients all of whom underwent thoracotomy with full mediastinal node dissection and histologic examination of the resected mediastinal and hilar lymph nodes. The authors find little to recommend \(^{67}\)Ga scintigraphy for evaluation of lung cancer patients who may have metastatic disease in mediastinal lymph nodes. A similar recommendation has recently been published by one of the groups who initially was very enthusiastic about \(^{67}\)Ga scintigraphy.\(^2\) It would appear that \(^{67}\)Ga scintigraphy is neither sensitive enough to detect microscopic metastases nor specific enough to define reactive nodes responding to concurrent or previous lung infections. These same faults plague mediastinal CT scanning, of course, and it may be that diagnostic imaging simply does not have a role in the preoperative evaluation of the mediastinum in lung cancer patients.

Ronald Neumann, M.D.
New Haven, CT

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Sarcoidosis, A New International Journal

A new journal devoted to the subject of sarcoidosis and other granulomatous diseases has appeared in September 1984. This bi-annual periodical is edited by Dr. D. Geraint James in association with the International Committee on Sarcoidosis. In his introduction, Dr. James noted that the journal “will be of interest to clinicians of every discipline and to radiologists, pathologists, immunologists, epidemiologists and geneticists—all of whom are now endeavouring to unravel our beloved enigma.” An Editorial Board member, Dr. Alvin S. Teirstein, emphasized that “Sarcoidosis is now recognized as the naturally occurring model for the study of immunologic abnormalities in the pathogenesis of disease.” A Swedish member of the Editorial Board, Dr. Ake Hansgren, noted, “It certainly seems appropriate that lymphocytes and macrophages should have a meeting place in a journal as well as in the human body.”

The American College of Chest Physicians congratulates Dr. James and the distinguished members of the Editorial Board on the inauguration of this splendid publication. Indeed, our society takes particular pleasure and vicarious pride in welcoming the appearance of a journal devoted to a discipline which is of unique interest to the members of the ACCP. Scientific reports of the congresses sponsored by the International Committee on Sarcoidosis have appeared in Chest in recent years. In addition, of course, a number of historic clinical investigations on sarcoidosis have been published in Chest. The interest and involvement of ACCP members in this discipline are evident as one peruses the names of the members of the Editorial Board. The following Board members of Sarcoidosis are Fellows of the American College of Chest Physicians and participants in our national and international programs: Drs. G. Rizzato, Milan, Italy (Associate Editor); A. Bisetti, Modena, Italy; A. Blasi, Naples, Italy; Y. Hosoda, Tokyo, Japan; L. Levinski, Prague, Czechoslovakia; R. Mikami, Nara, Japan; P. Rottoli, Siena, Italy; O. B. Selroos, Lund, Sweden; O. P. Sharma, Los Angeles; A. S. Teirstein, New York.

To the publisher and editors of Sarcoidosis, we say congratulations on an important and beautiful journal!

Alfred Soffer, MD, FCCP
Park Ridge, Illinois

YAG Laser Therapy
New Techniques and Conventional Wisdom

Laser therapy for palliation of malignant airway obstruction has passed the experimental stage and is becoming standard clinical practice at many large medical centers. The neodymium-yttrium-aluminum-garnet (Nd:YAG) laser is the best available instrument for opening airways obstructed by unresectable malig-