I would consider the alternative procedure of bronchoalveolar lavage to be clearly the safer and better procedure with equally satisfying results and a nicer "be happy" attitude for physicians and patients, especially in a university hospital where the paramount importance given to numbers and data have taken precedence over acceptable patient care.

Kudos to Drs. Robin and Burke of Stanford, California.

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REFERENCES


To the Editor:

"Men willingly believe what they wish (to have read)"
De Bello Gallico III, 18; Caesar, J.

We have read with keen attention Dr. Vevaina's comments concerning our article on the potential use of the less invasive transbronchial biopsy (TBB) vs open biopsy during mechanical ventilation in which we concluded that TBB "deserves further evaluation." We also read the thoughtful yet provocative, as always, commentary of Doctors Robin and Burke on the cost and benefits of open lung biopsy in immunosuppressed hosts. We fully agree that a prospective controlled clinical trial of both TBB and open lung biopsy utilizing meaningful survival as the outcome is essential to define the role of lung biopsy in immunosuppressed patients and selected patients with acute respiratory failure. Such a clinical trial must define subsets of immunosuppressed hosts, the prior determination of the likelihood of survival from the underlying disease process, etc. We are not as sanguine in predicting a negative outcome in a nonselective evaluation of all patients at risk, albeit it is our prejudice. On the contrary, one can reasonably expect to identify
certain groups in whom biopsy results will improve meaningful survival. Such a multicenter trial would require considerable external support and several years of data collection. The large number of patients seen each day who may benefit (live and be well) or lose (morbidity or mortality) firmly supports the need for such a study.

The writer's perception of risks is perplexing. Transient widening of the alveolar-arterial gradient clearly was not clinically significant; a similar, if not greater, widening will occur at bronchoalveolar lavage (BAL). A tension pneumothorax is indeed a risk in patients receiving positive pressure ventilatory support if it is not promptly recognized and satisfactorily treated. The relevance of citing tension pneumothorax during rigid bronchoscopic examination in a 6-day-old infant who survived is unclear.

We also thoroughly agree with David E. Reuben's editorial on "learning diagnostic restraint." We live and teach by example his basic principle of medicine: if the outcome of a test will change therapy in a patient, the physician should perform the safest test that will provide the necessary information to guide treatment. "To have delayed until these highly-selected patients were "off the ventilator" could have led to seeking post-mortem specimens.

We agree that there is no specific therapy for cytomegalic virus pneumonia. However, discontinuation of corticosteroid therapy did eliminate potential added immunosuppression in this patient who survived. A diagnosis of diffuse interstitial fibrosis requires tissue confirmation in a patient with rapidly progressive symptoms, bilateral diffuse disease on roentgenographic examination, and respiratory failure. One man's "dubious place at best" for corticosteroid treatment in DIF is a 30 percent physiologic response in the current literature,7 our living patient was amongst this number. We agree that hypersensitivity pneumonitis is a clinical diagnosis where the exposure history alone, or rarely, and with great care, a re-challenge, is diagnostic. However, rechallenge of a patient with hypersensitivity pneumonitis requiring mechanical ventilatory support is inconceivable; history will confirm the diagnosis, and steroid therapy is effective (revised Pink). This patient also survived. Although there are no clinically controlled trials, acetylcovor therapy is recommended for herpetic pneumonitis.

The conclusion that BAL is safer and better than TBB is rather subjective. Certainly, BAL sampling is incapable of indicating the diagnosis of malignant histiocytosis, hypersensitivity pneumonitis, diffuse interstitial fibrosis, or invasive fungal infections (organisms in BAL are not diagnostic). Dr. Reuben does not say that in a University Hospital...the paramount importance given to numbers and data have taken precedence over acceptable patient care? He does opine that this is often the case, but simultaneously identifies "a new breed of academicians... who are studying tests and their usefulness." He challenges the academic physician to "not equate this ability to know with the need to know." Clearly, we have suggested further evaluation of TBB, a less invasive procedure, when progressive infiltrates occur in acute respiratory failure requiring mechanical ventilation—not its adaptation. We believe that a 50 percent survival rate in this quite varied but extraordinary ill group of patients was cost-effective, to us and to each of them.

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REFERENCES

Spontaneous Bilateral Pneumothorax Due to Metastatic Cervical Carcinoma

To the Editor:

We read with interest the paper by Steinhauslein and Cuttatt (Chest 1985; 88:709-12) and agree with the authors that pneumothorax associated with carcinomatous involvement of the lung is associated with a grave prognosis, whether primary or secondary in origin. We wish to report a patient with spontaneous bilateral pneumothoraces as the presenting sign of pulmonary metastases from cervical carcinoma.

CASE REPORT

A 31-year-old black woman, with stage IV squamous cell carcinoma of the cervix, was admitted to the hospital with bilateral pneumothoraces. She was cachectic with stable vital signs and bilateral posterior chest tubes in place. Auscultation of the lungs revealed scattered rhonchi; cardiovascular examination was normal.

The patient was diagnosed as having metastatic cervical carcinoma seven months prior to admission (PTA) and received radiation to the lumbar spine and left ureter. Three months PTA she had a left pneumothorax which resolved spontaneously and recurred two weeks later, requiring chest tube placement. Bronchoscopic examination failed to reveal a diagnosis of neoplasm or interstitial lung disease. One month PTA she developed a right pneumothorax, with chest x-ray film demonstrating a cavitated lesion. Over a period of three weeks the right pneumothorax increased, requiring chest tube insertion. The right PTA she experienced acute shortness of breath with recurrence of the left pneumothorax. A chest tube was inserted and she was transferred from the chronic care facility to our hospital. Although she smoked one pack of cigarettes per day, she gave no history of underlying lung disease.

Upon admission, chest x-ray examination revealed chest tubes with residual pneumothoraces and a right mid-lung cavity (Fig I). Over a 48 hour period the right lung fully expanded. However, a persistent air leak prompted left thoracotomy. Wedge resection of the superior segment of the lower lobe was performed. During surgery, open bronchopleural fistula and necrotic tumor were found. Pleuradesis with tetracycline was performed, and anterior and posterior chest tubes were inserted. Pathology of the lesion demonstrated poorly differentiated metastatic squamous cell carcinoma.

The chest tube was removed after tetracycline instillation, and

![Figure 1. Anteroposterior chest roentgenographic film. Bilateral pneumothoraces with right mid-lung cavity. Bilateral chest tubes in place.](http://journal.publications.chestnet.org/pdfaccess.ashx?url=/data/journals/chest/21554/ on 06/21/2017)