sensitive enough to detect low concentrations of AB as can be found in patients with chest x-ray results suggestive of interstitial lung disease but without well-defined exposure to asbestos; in such cases, large amounts of fluid have to be processed and examined.

J. C. Yernault, M. D., F.C.C.P.;
P. De Vuyst, M. D., and
P. Dumortier,
Universite Libre de Bruxelles,
Hospital Erasme,
Brussels, Belgium

REFERENCES

An Error of Omission

To the Editor:

We read with great interest a recent article entitled "Posterior Mediastinal Sarcoidosis" by Rosseel et al (Chest 1986; 90:462-64). As the authors indicate, posterior mediastinal lymphadenopathy in sarcoidosis has rarely been recorded. It may be expected that frequent use of CT in these cases may change our current concept about the incidence of such involvement in the disease, and additional well-documented cases are valuable contributions.

It appears, however, that there may be an inadvertent error in the selection of illustrations reproduced in the article. While Figure 1A shows right paratracheal and Figure 2B demonstrates right paratracheal, anterior tracheal, prevenous and prearterial lymph nodes, the sections illustrating posterior mediastinal nodes are omitted. Their inclusion would markedly increase the intrinsic value of the paper.

Sheila D. Davis, M. D., and
Yahya M. Berkmen, M. D.,
Department of Radiology,
Division of Pulmonary Radiology,
New York Hospital-Cornell Medical Center,
New York

To the Editor:

We read with interest the comments of Drs. Davis and Berkmen on our recent article.

As they expect, with the frequent use of the CT-scan some authors have already reported an increased incidence of posterior mediastinal lymph node enlargement with bilateral hilar lymph node enlargement and various extrathoracic manifestations of sarcoidosis.1,2 (Schabel SI, et al. Radiology 1978; 129:591-93, Kutty CPK, Varkey B. Postgrad. Med. 1982, 71:64-66). However, we report two cases of posterior mediastinal lymph node involvement without any other extramediastinal disease.

In the first patient, the mass was dissected between the azygos vein and the esophagus, as is documented on Figure 1 (with right paratracheal extension at a more cranial level).

In the second patient, the mass was located again between the azygos vein and esophagus. To clearly demonstrate this, copies of the CT scan film at a lower level are inclosed (Fig 2).

B. Rosseel, M. D., and
B. Cham, M. D.,
Academisch Ziekenhuis,
Universiteit van Brussel,
Brussels, Belgium

REFERENCES
2 Kutty CPK, Varkey B. Postgrad Med 1982; 71:64-66

B. Cham, M. D.,
Academisch Ziekenhuis,
Universiteit van Brussel,
Brussels, Belgium

Reprint requests: Dr. Cham, Universiteit van Brussel, Academisch Ziekenhuis, 1090 Brussels, Belgium

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