Pulmonary Artery Obstruction

To the Editor:

The article, "Pulmonary artery obstruction due to giant cell arteritis" by Glover and colleagues (Chest 1987; 91:924-25) was noted with great interest.

The authors state that such a case has not previously been described. We like to draw attention to two recently published cases.1,2

In our patients, arteritis was restricted to the pulmonary elastic arteries in contrast to the case of Glover et al, in which the aorta also was affected at autopsy.

In our patients, diagnosis was made after surgical intervention and both patients are in a good condition without evidence of vasculitis in the lung or in other organs after seven and three years, respectively:

Sj. Sc. Wagenaar, M.D.;
J. M. M. van den Bosch, M.D., and
C. J. Westermann, M.D.;
St. Antonius Hospital,
Nieuwegein, The Netherlands

REFERENCES
1 Wagenaar Sj Sc, Westermann CJJ, Corrin B. Giant cell arteritis limited to large elastic pulmonary arteries. Thorax 1981; 36:876-77

Erratum

To the Editor:

Our names were inadvertently omitted from the letter in Chest 1987; 91:935, concerning serology and Pneumocystis carinii. We were participants in writing that letter and are in full agreement with the views expressed.

Marilyn S. Bartlett, M.S., and
James W. Smith, M.D.,
Indiana University School of Medicine,
Indianapolis

CME Accreditation

To The Editor:

Medical progress—as with all advances—moves forward by communication of ideas, comments, suggestions and constructive criticism. James Breeling's contributions to continuing medical education are well-known and his observations in the December, 1987 Chest are valuable in bringing the attention of your readers to the present state of continuing medical education quality assurance. While true at one time, some of his statements no longer reflect the operation of the Accreditation Council for Continuing Medical Education (ACCME) review and approval process. This illustrates the dynamic activity of the ACCME in response to concerns of representatives of the organizations named in the editorial, plus other members of the Council representing the general public and

Communications to the Editor

Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Specific permission to publish should be cited in a covering letter or appended as a postscript.

Bloody Pleural Effusion Secondary to Infarction of Omentum through a Non-traumatic Diaphragmatic Hernia

To the Editor:

We wish to report what may be the first case of bloody pleural effusion secondary to infarction of the omentum through a non-traumatic diaphragmatic hernia.

CASE REPORT

A 40-year-old white female asthmatic patient was admitted to St. Joseph Mercy Hospital on November 18, 1985 with incapacitating pleuritic left chest pain of two days duration. There was no history of trauma. Physical examination revealed absent breath sounds in the left lower lobe. Ventilation perfusion lung scan and pulmonary angiographic study were negative. Repeat x-ray film and two abdominal and chest CAT scans showed left pleural effusion and atelectasis. Two thoracenteses revealed bloody pleural fluid without bacterial growth or malignant cells. Bronchoscopy and pleural biopsy results were negative.

She was discharged on November 25, 1985 and readmitted three weeks later for open lung biopsy because of persistent pleural effusion. At surgery, through a small defect in the left diaphragm, a small piece of omentum was noted to have incarcerated and infarcted, which the left lower lobe was adherent. This was excised.

DISCUSSION

Omentum, usually with other viscera, through traumatic diaphragmatic hernias have been well documented.1 Bloody ascites from compromised omental bloody supply has been reported.2 Pirzada3 has suggested that omental strangulation in a diaphragmatic hernia is the common factor leading to bloody pleural effusion. Our case supports this concept.

Leonard Schreier, M.D.; Robert M. Cutler, M.D.; and
Vijay Saigal, M.D.,
Department of Internal Medicine,
Section of Allergy and Clinical Immunology,
St. Joseph Mercy Hospital,
Pontiac, Michigan

Reprint requests: Dr. Schreier, 1555 Woodward, Suite 101 Bloomfield Hills, MI 48013

REFERENCES
3 Pirzada FA, Snider GL. Diaphragmatic hernia. JAMA 1970; 214:2188-90

1314

Communications to the Editor