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.

Combined Apical Hypertrophic Cardiomyopathy and Coronary Artery-Left Ventricular Fistula

To the Editor:

Combined hypertrophic cardiomyopathy with coronary arteriovenous fistula is extremely rare. We report a unique patient who presented with apical hypertrophic cardiomyopathy associated with coronary artery-left ventricular fistula.

A 56-year-old Chinese man was referred for evaluation of chest pain. Clinical examination revealed a blood pressure of 130/60 mm Hg. No murmur was heard in the precordium. Mild cardiomegaly was seen on chest x-ray film. The 12-lead electrocardiogram showed tall R waves in leads V2 and V3, and deep T wave inversion in the precordial leads, especially in leads V3 and V4. Two-dimensional echocardiography revealed apical hypertrophic cardiomyopathy. Left heart catheterization and selective coronary angiography was then performed. This showed bilateral coronary artery-left ventricular fistula and apical hypertrophic cardiomyopathy (Fig 1).

Up to 1984, only three cases of combined hypertrophic cardiomyopathy with coronary arteriovenous fistula were reported in the literature. Interestingly, in all three cases the coronary fistula communicated with the pulmonary artery.1 Apical hypertrophic cardiomyopathy is relatively uncommon in the West but is frequent in Japan.2,3 Of all the coronary arteriovenous fistulae, coronary artery-left ventricular fistula is the rarest, seen in about 2 percent of cases. As of 1981, only 23 cases of coronary artery-left ventricular fistulae have been reported.4 However, the combination of apical hypertrophic cardiomyopathy and coronary artery-left ventricular fistula has not been previously described.

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3 Chia BL, Tan L. Apical hypertrophic cardiomyopathy. Am J Cardiol 1984; 53:1413
4 Chia BL, Chan AL, Tan LK, Ng RA, Chiang SE. Coronary artery-left ventricular fistula. Cardiology 1981; 68:167-79

Atypical Roentgenographic Manifestations of Pneumocystis carinii Pneumonia in AIDS

To the Editor:

We found the article by DeLorenzo et al4 of great interest. In this article, the radiologic manifestations of a group of patients with acquired immune deficiency syndrome (AIDS) and Pneumocystis carinii pneumonia (PCP) were analyzed. Although the classic bilateral alveolar or interstitial patterns were most frequently encountered, the authors also pointed out other atypical patterns that could develop in these patients, such as localized infiltrates, cystic or honeycomb lesions, hilar enlargement and spontaneous pneumothorax.

In the case of a drug addict with AIDS and PCP which we previously published,4 the radiologic presentation was also very atypical. Initial X-ray films showed lung abscess with an air-fluid level localized in the lower left lobe with ipsilateral pleural effusion. Pneumocystis carinii cysts were detected in a specimen obtained by transthoracic lung needle aspiration; bacterial, mycobacterial and fungal cultures of this sample were negative, as well as direct immunofluorescence staining for Legionella pneumophila (DFA).

The mechanism by which the Pneumocystis carinii infection could have brought about a lung abscess in our patient is unclear, since this microorganism does not appear to have sufficient necrotizing capacity of the lung parenchyma. Several infections (bacterial, mycobacterial, fungal) which are frequently encountered in these

![Figure 1. Left coronary angiogram in the left anterior oblique position. All the branches of the left coronary artery system are dilated. There is streaming of dye into the left ventricle via a maze of fine vessels from these branches. LAD = left anterior descending artery.](image-url)
patients could bring about these radiologic manifestations. Nevertheless, we believe that the microbiologic studies carried out in our patient reasonably ruled out this possibility. After treatment with trimethoprim-sulfamethoxazole, there was clinical improvement and the radiologic alterations were almost resolved. It is possible, however, that in other cases these abscesses could give rise to the cystic lesions observed by DeLorenzo et al.

We feel that our case demonstrates the need to add lung abscess and pleural effusion to the list of atypical radiologic images for patients with AIDS and PCP.

Sebastian de los Santos-Sastre, M.D.; Francisco Capote, M.D., and Antonio Pereira, M.D., Virgen del Rocio Hospital, Seville, Spain

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1 DeLorenzo LJ, Huang CT, Maguire GP and Stone DJ. Roentgenographic patterns of Pneumocystis carinii pneumonia in 104 patients with AIDS. Chest 1987; 91:323-27

To the Editor:

The information contained in the letter by de los Santos-Sastre et al is interesting and could be consistent with our report. However, we are not aware of other reports of Pneumocystis carinii having been identified in lung abscess or pleural fluid aspirate specimen. Transthoracic needle aspiration biopsy of pulmonary parenchyma has been useful in the past with some success to obtain specimen for identification of PCP. As such, one cannot be completely certain that the specimen used to identify PCP in the patient described by de los Santos-Sastre was purely abscess material.1

Trimethoprim-sulfamethoxazole is active against a variety of bacterial pathogens in addition to PCP. This could have accounted for the roentgenographic improvement if the "abscess" were the result of secondary bacterial infection. It is not uncommon for mixed bacterial infections of abscess fluids to be non-revealing on culture. Perhaps most importantly, in reviewing the hundreds of chest roentgenograms that preceded or followed the films which clearly showed our "cysts" and "honeycombing", none had the characteristic features of a "lung abscess" (ie, thick wall, air-fluid level, etc.) While the differentiation of a fluid-filled cyst and a lung abscess may at times be difficult, we do not believe that the cystic lesions we reported in Chest were the result of "abscesses" 2


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2 DeLorenzo LJ, Huang CT, Maguire GP, Stone DJ. Roentgenographic patterns of Pneumocystis carinii pneumonia in 104 patients with AIDS. Chest 1987; 91:323-27

CT to Evaluate Hemithorax

To the Editor:

With reference to the article by Schmid and De Haller (Chest 1986; 89:822-26), we would like to report a similar case recently evaluated at our institution.

The woman, aged 65 years, had undergone an extrapleural plombage for tuberculosis in 1953. She was complaining of chest pain for some months. The chest roentgenogram did not show any changes from the previous evaluation (Fig 1).

Computerized tomography (CT) of the chest (Fig 2) was irreplaceable in elucidating the extrapleural pocket and the fluid component of the opacity that proved to be sterile at thoracocentesis. The patient was discharged from the hospital without antituberculosis chemotherapy. Follow-up was normal.

According to our opinion, this case confirms that CT is essential when the extrapleural plombage appears, at the standard chest film, as a completely opaque hemithorax.

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FIGURE 1. Posteroanterior chest radiograph shows a complete homogeneous opacity on the right side; no evidence of parenchymal disease on the left.

FIGURE 2. CT scan through the upper thorax demonstrates, on the right side, the extrapleural plombage with a central area of decreased density due to fluid collection (arrow).