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.

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REFERENCES
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 typical characteristics 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


REFERENCES
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).