Roentgenographic Manifestation of Pulmonary Tuberculosis

To the Editor:

We read with interest the article by Farman and Speir* in which they stated that atypical roentgenographic presentation of lung tuberculosis is still uncommon in adults. This is in contrast with other studies** in which an increased frequency of unusual presentations similar to those in childhood are described (especially in older patients) and are attributed to the fact that these patients have outlived their initial infecting mycobacteria and become more susceptible to exogenous reinfection.

We reviewed the chest x-ray films from 114 adult patients with bacteriologically-proven lung tuberculosis diagnosed between 1981 and 1985. We made a subdivision between “usual postprimary tuberculosis” consisting of infiltrations (with or without cavitation) in the apicoposterior segments of the upper and/or lower lobes whether or not these were associated with other lesions, and “unusual” localisations without even minor inactive sequelae in the apicoposterior zones on tomographs (Table). We found no difference in presentation between patients younger vs older than 60 years of age (Table). Our findings were in agreement with those of Farman and Speir* and Hadlock et al., but in contrast with others.**

We conclude that, in our country, endogenous reactivations remain the main pathogenic pathway in the elderly. The difference between the published studies may at least partly be attributed to sometimes arbitrary differences in classification as usual or unusual form. We therefore agree with Kovnat† that the importance of a uniform classification should be stressed.

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Lysozyme Level of Pleural Fluid

To the Editor:

Verea Hernandez et al.† have reported that a ratio of the lysozyme level in the pleural fluid to that in the serum (PL/SL ratio) higher than 1.2 strongly suggests a diagnosis of tuberculosis when empyema has been excluded. They indicated that, at the present time, no conclusion could be drawn concerning an effusion due to a collagen disease.

Since this article appeared, we found a false-positive result in a 56-year-old woman suffering from rheumatoid arthritis for 20 years; she presented with dyspnea due to a large, right-sided pleural effusion. On thoracentesis, this proved to be a neutrophilic exudate (protein 3.64 g/dl [6.1 in the serum], LDH 2,688 U/L [230], WBC 600/µL with 68 percent polymorphonuclear neutrophils [PMN], many of them undergoing lytic changes). Typically, glycopleura was very low (3 mg/dl) and didn’t increase up to 180 min after a 25 g intravenous charge of glucose; rheumatoid factor was weakly positive; lactic acid was 10.6 mmol/L (1.1) and pH 7.03. Lysozyme determined by a turbidimetric spectrophotometric method‡ was 29.5 mg/dl in the pleural fluid, against 9.0 in the serum (PL/SL ratio 3.3). Bacteriologic study was negative, as were three specimens taken for Ziehl stain and Loewensteine culture. Cytologic examination was negative for malignant cells, but the CEA level was high (14.4 ng/ml vs 0.4 in the serum); this prompted us to carry out thoracoscopy. Parietal pleura appeared diffusely inflamed, with a finely granulous aspect in its lower part. Several biopsy specimens showed a mild mononuclear infiltration covered by strongly hyperplastic mesothelium.

This patient thus presented with features of rheumatoid pleurisy without any sign of tuberculosis; her PL/SL ratio was 3.3, well above the cutoff point and highly suggestive of a mycobacterial origin.

In a series by Klockars and Petterson,§ three of 13 patients with rheumatoid effusion also had a PL/SL ratio higher than 1.2; including our case, this represents 29 percent false positive results in this setting.

The origin of lysozyme in the pleural fluid of rheumatoid patients remains obscure; it might be explained by an extracellular release during the lysis of PMN, the mechanism involved in bacterial...