pressures. Better yet, transesophageal echocardiography is even more sensitive than precordial echocardiography in this respect.6

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REFERENCES

Pulmonary Involvement in Non-Hodgkin's Malignant Lymphomas

To the Editor:

We read with great interest the article by Rubin et al (Chest 1989; 96:948-49) about the possibility of cytologic diagnosis of pulmonary Hodgkin's disease from an endobronchial brush preparation.

We fully agree with their statements and wish to stress the importance of this approach for pulmonary involvement in non-Hodgkin's lymphomas as well, reporting a case that came under our observation.

A 61-year-old white man was admitted to our hospital with fever, anorexia, weight loss, diarrhea, episodic postprandial vomiting, and abdominal pain. At physical examination we found only moderate liver enlargement and abdominal pain in the left inferior quadrant.

Barium enema showed stenosis of the descending colon with ileocolic fistula. A chest x-ray film demonstrated widespread mediastinal lymph node enlargement and a bulky pulmonary mass in the right upper lobe. A segmental surgical bowel resection was performed due to the presence of an obstructive-inflammatory jejunal process, also conglobating the descending colon.

A histologic diagnosis of diffuse mixed non-Hodgkin's malignant lymphoma was made from surgical specimens (International Working Formulation).

Immunohistochemical studies revealed that tumor cells were stained by UCHL-1, while they were not stained by L26, kappa light chains, lambda light chains, or lysozyme (Dakopatts, Copenhagen, Denmark) using the avidin-biotin immunoenzymatic technique on paraffin-embedded sections. These data indicate that tumor cells were of T-cell origin.1

Since pulmonary findings did not improve after one course of combination chemotherapy with cyclophosphamide, doxorubicin, vincristine, and prednisone, a bronchoscopy examination was performed. Even though macroscopic examination showed a normal tracheobronchial tree, cytologic examination of bronchial aspirate and brushing revealed the presence of numerous pleomorphic, atypical lymphoid cells.

These cells showed a small amount of cytoplasm; round or ovoid nuclei with a fine, evenly distributed chromatin pattern; and, in some of them, small distinct nuclei (Fig 1).

The patient died 4 months after the first admission for acute purulent peritonitis from perforation of the small intestine. Autopsy was not performed.

Intrathoracic manifestations in non-Hodgkin's malignant lymphomas are quite frequent.2,3 In many cases a differential diagnosis with other conditions (such as infection and hemorrhage) may be difficult.4 We think that cytologic examination of endobronchial aspirate and brushing may prove useful in these patients and should be included in diagnostic and staging procedures.

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REFERENCES

Metastatic Choriocarcinoma of the Lung Presenting as Hemothorax

To the Editor:

A 25-year-old woman with a normally progressing pregnancy at 32 weeks presented with bilateral hemothoraces and nodular infiltrates on chest radiograph (Fig 1). After a normal male infant was delivered by cesarean section, thoracotomy revealed an ulcerated visceral pleural surface, and biopsy confirmed metastatic choriocarcinoma despite normal pathologic examination of the placenta. The patient had complete response to therapy with

Figure 1. Endobronchial aspirate. Pleomorphic abnormal lymphoid cells with round, ovoid, irregular nuclei and small amount of cytoplasm (Papanicolaou's stain, original magnification × 250).
methotrexate, actinomycin-D and cyclophosphamide, with subsequently normal β-human chorionic gonadotropin level.

Common clinical manifestations of pulmonary involvement with metastatic choriocarcinoma include hemoptysis, cough, and tumor emboli. However, a less commonly appreciated presentation is with nontraumatic hemothorax. Our patient demonstrates two important clinical points concerning choriocarcinoma. First, massive bilateral hemothoraces may complicate carcinomatous pleural effusion. Second, in any pregnant or postpartum woman, metastatic choriocarcinoma should be considered as a cause for spontaneous hemothorax despite an apparently normal pregnancy, delivery, and otherwise negative evaluation for metastases. C. David Sudduth, M.D.; Charlie Strange, M.D., F.C.C.P.; Berry A. Campbell, M.D.; and Steven A. Sahn, M.D., F.C.C.P., Medical University of South Carolina, Charleston

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REFERENCES


Errata

The editors of Chest wish to apologize to Steven L. Shepherd, M.P.H., for a typographical error that appeared in his article, "A Comparative Study of the Psychosocial Assets of Adults with Cystic Fibrosis and Their Healthy Peers" (Chest 1990; 97:1310-16). On page 1315, right-hand column, the following sentence appeared: "They had married and gained dependents at the same rates as had members of the comparison group and the occupational status attained by those who had never entered the work force was at least as good as that attained by members of the comparison group." It should have read: "attained by those who had ever entered the work force . . . ." In the article "Prophylactic Antibiotic Usage in Cardiothoracic Surgery" (Chest 1990; 96:719-23), the first sentence of the last paragraph on page 722 should read: "In this survey, the surgical membership of the American College of Chest Physicians clearly agrees that prophylactic antibiotics are a requirement in today's major cardiothoracic surgical procedures."