The Malignancy-Sarcoidosis Syndrome

To the Editor:

In an article that appeared in the November 1990 issue of Chest, Suen et al described six cases of malignant disease followed by sarcoidosis with intervals varying from seven to 108 months. The authors stated that there may be a causal relationship between malignant disease and the subsequent development of sarcoidosis, but they did not offer any evidence to substantiate this belief. Remarkably, they give only two references to three similar cases in their article, although no less than 21 such cases have been reviewed and analyzed previously by the present author. In addition, three further cases have been described elsewhere.

Regrettably, a thorough analysis of all 30 cases on record, including the six cases reported by Suen et al, does not show any consistent features that can substantiate a belief in a causal relationship between malignancy, or treatment of malignancy, and the subsequent development of sarcoidosis. Clearly, it is not justified to speak of a syndrome just because one disease precedes another fortuitously.

In contrast, the present author's description of a sarcoidosis-lymphoma syndrome was based on two separate studies showing an increased incidence of lymphoma in sarcoidosis and a review of 65 reported cases of this association showing (1) a nonrandom temporal relationship between sarcoidosis and lymphoma (sarcoidosis almost invariably preceding lymphoma), (2) a nonrandom distribution of theYTE and the chronic types of sarcoidosis (chronic type predominant), and (3) a nonrandom sample of lymphoma types (Hodgkin's disease occurring three times more frequently than expected).

In conjunction with other similar cases, the six cases described by Suen et al may contribute to our understanding of the relationship between malignancy and subsequent sarcoidosis. However, as long as there are no indications of any causal relationship, any claims of the existence of a "malignancy-sarcoidosis syndrome" are not justified.

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REFERENCES

To the Editor:

We appreciate the comments and additional cases that were highlighted by Dr Brincker. We drew a very cautious conclusion in our article, indicating that "a distinct malignancy-sarcoidosis syndrome may exist in which malignancy and/or chemotherapy predisposes to the development of sarcoidosis." We further indicated that "prospective studies are needed to confirm such an epidemiologic association." We did not indicate that we had established any causality between malignancy and sarcoidosis, especially when the malignancy clearly precedes sarcoidosis. As pointed out by Dr Brincker and as we indicated in our article, retrospective analysis of all the reported cases to date would suggest that there is perhaps a causal association when sarcoidosis precedes lymphoma. As new cases are being reported from various centers, we do not feel that it is totally wrong to postulate that there is perhaps an association when malignancy precedes sarcoidosis. We may perhaps be too narrow-minded if we think that all streets should be one-way.

We hope that Dr Brincker will join us in continuing to accumulate cases, and perhaps a few years from now, when a sufficient number of cases have become available, a causal association analysis can be carefully conducted.

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Pneumothorax during Pulmonary Toxoplasmosis in an AIDS Patient

To the Editor:

Toxoplasma gondii is the most common cause of focal brain lesions in human immunodeficiency virus (HIV)-seropositive subjects, but pulmonary involvement is rare. We report a case of pneumothorax during the course of toxoplasmosis pneumonia.

A 35-year-old HIV-positive male drug addict was admitted to our Department of Infectious Diseases with a two-week history of dyspnea, fever, unproductive cough, asthenia, weight loss, cyanosis, and dysphagia. The chest roentgenogram showed a unilateral alveolar-interstitial infiltrate with cavitation of the right upper lobe. Sputum cultures and Pneumocystis carinii investigation were negative. Fiberoptic bronchoscopy with transbronchial biopsy showed tachyzoites of T gondii. The patient was treated with sulfadiazine (4 g/d), pyrimethamine (100 mg/d), folic acid (30 mg/d), and fluconazole (200 mg/d).

Thirty days after the admission, acute chest pain and dyspnea appeared. A chest roentgenogram revealed a 75 percent right pneumothorax and persistent cavitation. A new therapeutic regimen of sulfadiazine (6 g/d) and pyrimethamine (300 mg/d) was started. A thoracostomy tube was placed, and the lung reexpanded. The tube was removed 20 days later, and the patient was discharged on the 36th day with minimal lesions in the right lung. Therapy with sulfadiazine (3 g/d), pyrimethamine (50 mg/d), and folic acid (30 mg/d) was continued for six weeks. The patient is now asymptomatic.

On the basis of this experience, we believe that pneumothorax should be considered in patients with pulmonary toxoplasmosis and respiratory failure.

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Communications to the Editor