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.

Chylothorax Due to Benign Lymphangioma

To the Editor:

The etiology of chylothorax is best classified as congenital, traumatic, neoplastic, or infectious. Most commonly, the causes are trauma and neoplasm. Occurrence of nontraumatic chylothorax necessitates a search for neoplasm, usually lymphoma. The neoplasm is rarely benign. We recently treated such a case of spontaneous chylothorax due to benign lymphangioma.

A previously healthy 46-year-old man was first evaluated in the emergency room for a two-day history of fever, chills, dyspnea, and nonproductive cough. On physical examination, a pericardial friction rub was audible. A chest radiograph revealed interstitial edema and a widened mediastinum, consistent with mediastinal adenopathy. The patient was placed on a regimen of antibiotics as well as indomethacin and furosemide. He recovered quickly and was discharged four days later.

A chest x-ray film obtained three months later once again revealed mediastinal adenopathy, which was confirmed with computed tomography. Mediastinoscopy with biopsy was performed, and a histologic diagnosis of benign lymphangioma was made (Fig 1). This diagnosis was confirmed at a nearby university teaching facility.

Two months later, the patient noted progressive shortness of breath. A chest x-ray film revealed a large right pleural effusion. Thoracentesis confirmed this to be a chylous effusion, which recurred quickly despite a low-fat diet. He was subsequently hospitalized, and 3,800 ml of chyle was drained with a right thoracostomy tube. Drainage exceeded 1,000 ml/d for three days. On the fourth day, thoracic duct ligation and parietal pleurectomy were performed through a right thoracotomy. Postoperatively, all chylous drainage ceased, and the postdischarge chest radiograph revealed no pleural effusions.

Lymphangiomas are considered benign lesions that arise from sequestrations of lymphatic tissue that fail to communicate with the venous system. Uncommonly, lymphangiomas may be acquired lesions arising on an obtrusive basis following surgery, irradiation, or infection. The antecedent history of probable pericarditis in this patient may have been the inciting event resulting in mediastinal lymphatic obstruction and subsequent chylothorax. To our knowledge, this is the first reported case of chylothorax secondary to benign lymphangioma in an adult.

The ideal management of chylothorax remains controversial. Methods used include drainage with total parenteral nutrition, chemical pleurodesis, pleuropertitoneal shunting, and instillation of intrapleural fibrin glue. Malignant chylothorax is best treated with radiation therapy. Thoracic duct ligation with parietal pleurectomy remains the most definitive treatment for chylothorax unresponsive to conservative measures and was successfully performed in this case.

In conclusion, benign lymphangioma in the adult should be added to the differential diagnosis of spontaneous chylothorax and is best treated by thoracic duct ligation and parietal pleurectomy.

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References


Treatment of Bronchopleural Fistulas

To the Editor:

I read with great interest the case report by Martin et al., which appeared in the April 1991 issue of Chest. I found the method to be essentially identical to what I did, which I reported in the November 1987 issue of Chest. The major difference was that they used tetracycline instead of doxycycline, which I used. The authors apparently were not aware of our report, since they did not cite it. I am very interested in their report on the fate of the treated bronchus, which was sclerosed at the site of tetracycline administration. In the past five years, we have conducted a study to measure the efficacy of this technique in 18 patients with bronchopleural air leaks of varying degrees which had existed for varying periods of