between the cavity and the bronchus. Peripheral dense nodules, especially nonmalignant ones, are not frequently in direct communication with airways, and the success of TBB depends on the possibility of reaching a bronchus that will lead forward or into the lesion.

We conclude that TBB during fiberoptic bronchoscopy appears to be an effective method for investigation of CPPL.

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REFERENCE

Utility of Admission Chest Radiography in Management of Acute Asthma in Adults

To the Editor:

In the July 1991 issue of Chest, White et al describe the utility of admission chest radiography in the management of adults admitted to the hospital with acute asthma. They conclude their article with a recommendation for routine chest radiography in this patient group.

As a radiologist, I am concerned with several aspects of this report. Two radiographic findings that were significantly associated with subsequent antibiotic use were described as "focal opacity" and "increased interstitial markings." In a subset of patients, the presence of these opacities appeared to prompt antibiotic prescription, even in the absence of clinical indicators of infection. I do not know what pathologic findings these descriptors are intended to indicate. With respect to pathophysiologic abnormalities characteristic of asthma, focal opacities may represent areas of focal atelectasis and/or bronchial mucus plugs. I believe that neither of these entities, as isolated radiographic findings, necessitates antibiotic therapy. Bacterial pneumonia appears on a radiograph as air-space consolidation, typically segmental or lobar in distribution. Apparently, this finding was not described in any patient in the authors' series. Parenchymal infiltrative disease that may result in abnormal "interstitial" opacities is not a feature of asthma.

I accept the fact that some patients with these opacities were subsequently treated with antibiotics. However, we do not know which patients actually had bacterial pneumonia, if any. Some may have had acute bacterial bronchitis, but this disorder does not produce parenchymal opacities. As physicians, we should attempt to determine which diagnostic and management strategies actually improve clinical outcome before recommending "routine" diagnostic tests. Although this was obviously not the specific intent of the authors' investigation, we should view their recommendation with appropriate skepticism.

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REFERENCE

Pneumothorax Due to Pleural Perforation of a Pseudocavity Containing Aspergillomas in a Patient with Allergic Bronchopulmonary Aspergillosis

To the Editor:

A 22-year-old man was hospitalized for treatment of a cavitary lesion complicated by pneumothorax. He had a history of childhood asthma, which remitted during adolescence. One year previously he developed a cough, which produced purplish phlegm sometimes accompanied by plugs of dark material. A chest radiograph revealed tram lines and tubular shadows in the left upper lobe. Fiberoptic bronchoscopy and serologic tests confirmed a diagnosis of allergic bronchopulmonary aspergillosis (ABPA), for which the patient received corticosteroid therapy.

A cavitary lesion that evolved in the left upper lobe exhibited two unusual features: the lesion lacked continuity in its inferomedial aspect, and excrescences protruded from its inner wall. A computed tomographic (CT) scan, performed during a hospitalization for symptomatic pneumothorax, revealed central bronchiectasis and a cavity that contained three discrete masses (Fig 1).

The patient underwent an uncomplicated lobectomy while receiving perioperative amphotericin B therapy, to a total dose of 145 mg. The pathologic findings were those of ABPA; the "cavity," which had perforated the pleural surface, was an aneurysmal expansion of an ectatic central bronchus that contained several aspergillomas.

Aspergilloma complicating ABPA has been reported. The putative mechanism is focal dilatation of the ectatic bronchi, consequent to the accretion of materials produced by the immune response...