I would like to categorically oppose the use of this procedure by pulmonologists who are not versed in thoracic surgery.

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To the Editor:

At Mercy Hospital and Medical Center here in San Diego, where I am the Medical Director of Respiratory Care, several of my colleagues in pulmonary medicine have taken postgraduate courses and are embarking on performing diagnostic thoracoscopy.

I remember attending a course about 15 years ago, and while it was intriguing, I never quite saw a wide enough application in my own practice to persevere. Times have changed, however, and I believe it is important that the American College of Chest Physicians encourage pulmonologists throughout the country to take up this useful procedure.

Further, I believe it is well within the capability of a competently trained pulmonary physician to perform. It is another example of procedures that have previously been in the realm of thoracic surgeons now becoming part of pulmonary medicine as well.

I believe that the practicing pulmonary physician has a lot to offer patients with undiagnosed pleural effusions by using thoracoscopy, and that our professional organizations should support this.

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To the Editor:

I attended a course given by Long Beach Memorial Hospital, which was taught by Christian Boutin and Yo Aekony, as well as others who have performed thousands of thoracoscopies and are themselves pulmonologists. There was a thoracic surgeon also speaking at the meeting, and he reiterated his belief that thoracic surgeons alone should be allowed to perform this procedure. This was not at all the sentiment of Dr. Boutin or the other speakers.

I myself work at Mercy Hospital in San Diego, and we are in the process of trying to establish thoracoscopy as a diagnostic tool for the pulmonologists. As you might guess, there is a great deal of resistance on the part of the thoracic surgeons. Their arguments are for the most part spurious and self-serving. I have attended several thoracoscopies performed by a thoracic surgeon, and I have found my presence in the operating room invaluable (since this was for the most part a diagnostic procedure) and have on more than one occasion limited the size and extent of the incision performed.

I appreciate the effort that you are making to mobilize the community of pulmonologists, and I am sure that with time the medical community as a whole, and patients in particular, will come to realize that having their diagnostic workup performed by one person who thinks it through is ultimately in their best interest.

Lucien N. Jassy, M.D., F.C.C.P.,
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To the Editor:

It is quite apparent that many pulmonologists place chest tubes, as do general practitioners. This has been acceptable practice, and I would think it would be unrealistic to attempt to restrict chest tube placement to thoracic or general surgeons. In the same fashion, it would appear that thoracoscopy is a procedure that could indeed be performed by qualified nonsurgical physicians. I do think that care would have to be exercised in the training of such physicians, but I do not believe that the procedure by itself necessitates the ability to immediately perform a thoracotomy.

At the current time, it is apparent that the American Association for Thoracic Surgery and the Society of Thoracic Surgeons are recommending that this procedure be restricted to thoracic surgeons only. I believe that this is unnecessarily limited. It would be a more acceptable position if the procedure were limited to physicians who have been adequately trained in the procedure. The setting up of some type of a credentialing process for this procedure would, I think, be the best outcome for patients and medical care in general, rather than defining who can do it on the basis of professional subspecialty.

Your attention to this matter is appreciated.

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Hydatidosis with Pericardial Involvement

To the Editor:

We read with great interest the case report of Mandke and Sanga 
di, which appeared in the April 1991 issue of Chest. We report here a case of systemic hydatidosis involving the abdominal as well as the thoracic viscera, such as the left lung, pleura, and pericardium. Such extensive hydatidosis is very rare.

A 25-year-old farmer was admitted to the hospital with cough, expectoration, weight loss, and thoracic pain. The sputum was mucopurulent. There was no history of hydatid fluid expectoration. The chest x-ray film revealed cardiomegaly and homogeneous opacity in the lower and middle regions of the left lung. Echocardiography showed minimal pericardial effusion and hypertrophy of the left ventricle. Computed tomography revealed multiple cysts near the aortic arch, in the paracardiac and paravertebral regions, on the thoracic wall, and in the upper portion of the abdomen, which shifted the spleen (Fig 1). There was no bronchial spread in

Figure 1. Computed tomogram reveals multiple cysts near the aortic arch, in the paracardiac and paravertebral regions, on the thoracic wall, and in the upper portion of the abdomen.
the right lung when investigated by fiberoptic bronchoscopy and computed tomography. Computed tomographic findings in the central nervous system were normal. Casoni and Weinberg tests were strongly positive.

Left thoracotomy was performed. The pleura and lower lobe were infiltrated with hydatid cysts, and there was a cyst in the pericardium. There was no evidence of cardiac cysts. The pericardi- dits and pericardial cyst were considered to be due to rupture of lung hydatid cysts. Lower lobectomy was performed, and the cysts were cleaned out. Most of the cysts were intact, and a few of them were ruptured. Pathologic examination revealed multiple hydatid cysts. The patient’s recovery was uneventful. Surgical excision of the abdominal cysts is planned in the near future because of the chance of recurrence of systemic hydatidosis.

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Air Embolism during Attempted Central Line Placement

To the Editor:

The case report of Clance and Glauser,1 which appeared in the August 1991 issue of Chest, states that air entered the central circulation after cannulation of the internal jugular vein during insertion of the guide wire with the patient in the Trendelenburg position. Given the large quantity of residual air seen on the x-ray film after the resuscitation, it would seem that a very large bolus of air must have formed or that air entry continued after the initial bolus. A large volume of air is further suggested by the findings in two animal studies: in one study in dogs weighing 10 to 21 kg, 125 ml of air was required to produce apnea;2 in another study, cardiac dysrhythmia was seen after administration of a bolus of only 1.5 to 2.0 ml of air per kilogram of body weight.3

It is possible that the patient gasped with a small initial air embolus, which increased the gradient for air entry into the venous circulation, thus causing a larger bolus of air to follow. However, one would expect to see evidence of air in the heart. It is also possible that the patient experienced a "paradoxical air embolism,"4 wherein a small quantity of the air that entered the venous circulation passed through to the heart and traversed a patent foramen ovale, atrial septal defect, or ventricular septal defect producing coronary or cerebral arterial air embolism and therefore cardiorespiratory arrest. This is possible given the data as reported in the case and the lack of information concerning the condition of the patient after this event.

The therapeutic approach suggested by the authors is confusing. Cardiopulmonary resuscitation (CPR) was the only option given the situation facing the authors. Establishing central venous access and aspiration of air should also be considered during supine CPR. The use of the left lateral decubitus position, in our experience,5 is practical only if cardiovascular collapse has not already occurred. If the left lateral decubitus position is used, an attempt should be made to aspirate air from the venous circulation to prevent air entry into the heart.6 In a comparison of resuscitative techniques, Alvaran et al7 have demonstrated a shorter resuscitation time (2.7 min) with intracardiac aspiration of air as compared to left lateral decubitus positioning (19.5 min) and cardiac massage (19.3 min). Finally, we would caution that the use of central venous catheters for aspiration of air from the venous circulation is not controversial, as stated by the authors. In fact, preoperative placement of central venous catheters, and occasionally specially designed multiorifice right atrial catheters, in patients who are at risk for air embolism during surgery is routine in anesthesiology practice.

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Apical Pneumocystis carinii Pneumonia Associated with HIV Infection

To the Editor:

We read with interest the report by Shin et al,1 which appeared in the November 1991 issue of Chest. They described the radiologic appearance of apical Pneumocystis carinii pneumonia mimicking tuberculosis in two patients with AIDS. Although radiologically documented apical presentations of Pneumocystis pneumonia have been reported,2 these have occurred in patients receiving inhaled pentamidine prophylaxis, which was thought to have affected the radiologic picture.

We, too, have recently had the opportunity to treat a patient who presented with cavitary apical infiltrates suggesting tuberculosis on chest roentgenography and on chest computed tomography (CT), which subsequently proved to be due to P carinii infection.

A 52-year-old woman with no relevant past medical history was admitted to our hospital with a febrile illness characterized by a nonproductive cough and dyspnea. The chest x-ray film (Fig 1) and CT scan of the chest showed apical infiltrates with cavitation and pleural involvement suggestive of tuberculosis. The complete blood cell count and blood chemistries were normal. Fiberoptic bronchoscopy was performed with biopsy of the upper lobes and bronchoalveolar lavage (BAL) of the right middle lobe. The biopsy and BAL specimens both revealed Pneumocystis pneumonia. The patient was treated with trimethoprim-sulfamethoxazole and recovered uneventfully with no suggestion of tuberculosis on long-term follow-up. Western blot analysis of her blood showed positivity for HIV type 1, with 58 total CD4 helper cells.

We report this case to augment the report of Shin et al1 and to suggest that this radiologic presentation of P carinii pneumonia in untreated AIDS patients may be more common than has been previously appreciated. In addition, this presentation of Pneumocystis pneumonia does not imply any form of coinfection. Although radiologic involvement was limited to the upper lobes in our patient,