Finally, we would like to underscore that all patients with PPH should be tested for HIV infection. Testing can no longer be based on a history of high-risk behavior, because the prevalence of HIV infection is steadily increasing in nontraditional risk categories, such as heterosexuals. In Switzerland, for instance, in 1991 17.3 percent of all new AIDS cases occurred in heterosexual patients.1

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REFERENCES

Diagnosis of Mycobacterial Mediastinal Lymphadenopathy by Transbronchial Needle Aspiration

To the Editor:

I read with great interest the case report by Baron and Aranda,1 which appeared in the December 1991 issue of Chest.

In the past I was nearly daily faced with intrathoracic lymphadenopathies and with the problem of how to proceed in establishing the correct diagnosis as soon as possible. Therefore, we developed some procedures and special needles4 for pertracheal and perbronchial diagnostic puncture at the time of bronchoscopic examination. We used this technique by gas insufflation in pneumomediastinography,5 as well as for aspiration in the examination of intrathoracic lymph nodes (eg, in the diagnosis and staging of malignant tumors [with proved metastases in 58.7 percent of 1,366 lung cancer patients]6 and in cases without evident radiographic enlargement. The effectiveness of our procedure was based on an anatomic study of the topography of selected nondiseased intrathoracic lymph nodes in relationship to the tracheobronchial tree, with estimation of their mean size.

In cases of suspected sarcoidosis or tuberculosis, we used aspiration specimens for cytologic examination and preliminary rapid evaluation (the next day) by means of passive transfer of tuberculin hypersensitivity with the aid of intraperitoneal guinea pig injection, which is the first step in demonstrating virulent mycobacteria by animal inoculation. The third part of the specimen was cultured.

In 1967 we reported positive results of culture and/or guinea pig inoculation using intrathoracic lymph node needle aspiration in 18 cases (24 percent of 75 examined patients).7 In 1970 we published our success in establishing the presence of pathogenic Mycobacterium tuberculosis by culture and animal inoculation by needle aspiration of intrathoracic lymph nodes in three of 196 cases with the typical clinical picture of sarcoidosis.8

Therefore, the article by Baron and Aranda is not the first report of mycobacterial intrathoracic lymphadenopathy diagnosed by means of transbronchial needle aspiration in a medical journal or monograph.

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To the Editor:

During the time when we were writing our article, our search of the English-language medical literature failed to reveal other cases of intrathoracic mycobacterial lymphadenopathy diagnosed by transbronchial needle aspiration (TBNA) in the manner we described. The search was not extended to the non-English-language medical literature; hence, we were not aware of Dr Šimeček's articles.

Nevertheless, we appreciate Dr Šimeček's pointing out that intrathoracic mycobacterial lymphadenopathy has been diagnosed by TBNA biopsy through a rigid bronchoscope. This further supports our recommendation that when performing TBNA (which, in the majority of cases, is now being done through the fiberoptic bronchoscope), aspirates should be obtained for acid-fast smear and culture if a diagnosis of mycobacterial disease is being entertained. Intraperitoneal guinea pig inoculation of aspirates, to our knowledge, is currently not being done routinely to diagnose tuberculosis.

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The APACHE III Prognostic System

To the Editor:

We are writing concerning the article by Knaus et al.,1 which appeared in the December 1991 issue of Chest. In that article the authors compare the overall correct classification rates, based on 2 x 2 classification tables with 0.50 cutpoint, for our Mortality Probability Model (MPM)4 and the APACHE III system. The MPM system consists of distinct models at admission to the intensive care unit (ICU), at 24 h, and at 48 h. The authors correctly chose the 24-h MPM, rather than the admission MPM, as the basis for their comparison with APACHE III, but their figure of 79.1 percent total correct classification for the MPM is incorrect. That number appears in a table in an article in which values are given for patients in the ICU for 48 h or more. The accurate overall correct classification rate for the 24-h MPM, given in the text of the article, is 84.9

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percent, much closer to the APACHE III rate of 88.1 percent than the value presented. This error in research was probably inadvertent, but is nevertheless misleading.

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REFERENCES

To the Editor:

We agree. We used a figure from Table 6 of the article by Lemeshow et al., which was for a restricted set of patients. The correct overall classification from the study was 84.9 percent, achieved with the patients from a single hospital as compared with a correct classification of 88.1 percent with APACHE III on a 40-hospital data base. We emphasize, however, that because of the bias inherent in trying to compare correct classification rates across data files that have varying baseline outcome rates, we prefer receiver operating characteristic (ROC) areas. For the specific issue of predicting hospital death rates, ROC areas are even more useful, since the conventional threshold of a 0.50 risk of death used in the above correct classification calculations is arbitrary. The APACHE III system achieved a 0.90 ROC area.

We also would like to take this opportunity to correct one error in our APACHE III article. The sex ratio was reversed. The correct distribution of sex across ICU admissions is 55.2 percent male and 44.8 percent female. Sex has no relationship with outcome and is not used in any APACHE outcome predictions.

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Magnetic Resonance Imaging of Thymic Squamous Cell Carcinoma

To the Editor:

Recently, magnetic resonance (MR) technology has provided specific signal intensities for thymic squamous masses. Typical thymoma has been reported to show a signal intensity intermediate between the intensities of muscle and fat on T1-weighted images and an intensity almost equal to that of fat on T2-weighted images.1 2

We encountered a 65-year-old man presenting with typical symptoms of myasthenia and the rare complication of thymic squamous cell carcinoma.1 4 Histologically, the tumor contained many nests, calcified in part and surrounded by thick fibrous bands. Hassall’s corpusculiform figures, monocytic keratinization, and intercellular bridges were also noted.

An MR imaging study of the chest (Fig 1) was obtained with a 0.5-T superconducting system (SMT 50, Simazu, Kyoto, Japan).

![Figure 1. A T2-weighted image (relaxation time, 1,400 ms; echo time, 100 ms) shows an intermediate-intensity mass containing some low-intensity spots. Intensity of fat tissue is high, and fat can be easily distinguished from tumor.](http://example.com)

To the Editor:

The intermediate signal intensity of the mass on the T1-weighted images was compatible with that of thymoma. On T2-weighted images, the intensity of the tumor was lower than that of fat, and the tumor contained some areas of much lower intensity. According to Molina et al., these findings probably correspond pathologically to septation and calcification. This is, to the best of our knowledge, the first report on the MR appearance of thymic squamous cell carcinoma in a case in which myasthenic symptoms led to detection of the tumor.

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REFERENCES

Reexpansion Pulmonary Edema

To the Editor:

We read with great interest the article by Matsuura and colleagues, which appeared in the December 1991 issue of Chest. In reporting their experience with reexpansion pulmonary edema in a