detect more subtle adverse consequences of talc in moribund patients with underlying malignant conditions in the reported retrospective studies.

I was surprised to read in Dr Aelony's letter that either of my past associates, Drs Antony and Sahn, had become talc poudrage "enthusiasts." Recent communications with them reassure me that they still favor TCN (now minocycline or doxycycline) pleurodesis and do not personally employ or recommend the primary use of thoracoscopy with talc poudrage (oral communication, February 20, 1992). I submit that reasons other than a "shortage of skilled thoracoscopists in the English-speaking world" explain why thoracoscopic talc poudrage has not caught on in this country as the primary pleurodesis procedure. Thoracoscopic pleurodesis is overly invasive, expensive, and cumbersome compared with chemical pleurodesis, which can be performed through small-bore (7F to 24F) percutaneous chest catheters. Furthermore, thoracoscopy provides poorly documented advantages in outcome compared with meticulously correct performance of TCN pleurodesis with 20 mg/kg or 1.5 g of the drug.

Pulmonologists are rightly enthusiastic about the future of thoracoscopy in the hands of physicians performing such procedures as bulllectomies, pulmonary resections, lung biopsies, drainage of loculated empyemas, and pericardial windows. Thoracoscopy talc poudrage will certainly have a role in some clinical situations. We should expect, however, that unbridled enthusiasm for talc poudrage as the pleurodesis procedure of choice would be matched with careful scholarship and thoughtful analysis of its benefits compared with simpler and less costly techniques that have been similarly effective.

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To the Editor:

Dr Aelony reports the case of a patient who had received mediastinal irradiation for Hodgkin's disease in 1979 and six years later developed relapse of the lymphomatous disease (pneumocarcinomatous and mediastinal lymph node involvement) and bilateral pleural effusions. The lymphoma responded to chemotherapy, but the pleural effusions recurred over several weeks to months. I think that the pleural effusions in this patient could have been secondary to mediastinal nodal involvement (Hodgkin's disease), and that pleural fluid removal went slowly because of some degree of mediastinal fibrosis induced by radiation therapy.

In our patient, the presence of other nonmalignant complications of radiotherapy (pericardial effusion, exsanguine dyspnea with restrictive impairment of lung function due to radiation pneumonitis, and subclinical hypothyroidism demonstrated by increased serum levels of thyroid-stimulating hormone) reinforced the role of radiation therapy in the development of pleural effusion. On the other hand, few data are available concerning the rate of removal of pleural effusion related to Hodgkin's disease after cure of nodal disease. Effusions might persist with the amount of fluid decreasing slightly.

On follow-up, our patient had recurrent small pleural effusions that responded to anti-inflammatory drugs. At present there is no evidence of lymphomatous recurrence. Although the presence of pleural effusion in lymphoma is a poor prognostic sign, prolonged survival has been observed in patients responsive to chemotherapy. If the patient has mediastinal adenopathy without parenchymal or pleural nodules, there is a good likelihood of control of the effusion following either either radiation or chemotherapy. If these measures are not effective, pleurodesis should be attempted. Moreover, one must take into account the undesirable degree of fibrosis and granulomatous reaction that may result from pleurodesis and that may interfere with proper ventilatory motion of the lung. Talc poudrage may cause mild restrictive impairment of lung function, thus increasing the severity of dyspnea in patients with lung fibrosis induced by radiation therapy.

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