cally, it can start with just tiny dissecting air spaces in the interstitium and can progress all the way to huge cystic or bullous formations. The term "malignant PIE" was first used by Macklin and Macklin\(^2\) to stress that in certain cases this form of pathology can become so severe and destructive that it interferes with the cardiopulmonary system and affects the survival of the patient. We suggest that malignant PIE should be included as a unique form of barotrauma and that the term should be applied to those who develop significant functional impairment in the cardiopulmonary system as a result of destructive PIE.

With the tremendous advances in both the concept and the technology of mechanical ventilation over the past two decades, the time has come to reiterate the importance of preventing this basic but potentially devastating complication of barotrauma. This is probably one of the things that we can do to reduce the persistently high mortality of ARDS.\(^6\)

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**Unilateral Spontaneous Pneumothorax Mimicking Bilateral Pneumothorax**

*To the Editor:*

We would like to report an interesting case that we recently encountered.

A 37-year-old man was diagnosed on the basis of the chest radiographic findings to have bilateral spontaneous pneumothorax. He had a history of chest trauma when he was 5 years old, but the details were unclear. On the chest x-ray film, an air space was present in upper pleural cavity bilaterally. Mediastinal shift to the left, double contour of the left cardiac border, and silhouetting of the descending aorta and the left hemidiaphragm were also present. Because the abnormal findings on the chest x-ray film persisted even after the expansion of the lungs by bilateral chest tube drainage, fiberoptic bronchoscopy was performed. Bronchoscopy revealed interruption of the left mainstem bronchus 2 cm distal to the tracheal carina. A biopsy forceps inserted through the right middle lobe bronchus reached the left hemithorax (Fig 1). The diagnosis was corrected to right spontaneous pneumothorax with traumatic disruption of the left mainstem bronchus.

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**Diagnostic Difficulties in Community-acquired Pneumonia**

*To the Editor:*

I read with great interest the article on the diagnosis of community-acquired pneumonia (CAP) by Pareja et al,\(^1\) which appeared in the May 1992 issue of *Chest.*

There are two important questions in the diagnosis of CAP. First is the question whether the patient with suspected CAP really suffers from pneumonia. Second, if the answer is yes, is the question of the identity of the causative organism. Many authors have recently examined the possibilities and results in the etiologic diagnosis of CAP, but only a few have analyzed the differential diagnostic problems in detail.

In the study of Pareja et al, the diagnosis was proved in only 165 of 348 adult patients hospitalized with suspected CAP. The other patients were excluded because of unusual conditions or other causes.

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**FIGURE 1.** Radiograph shows that a biopsy forceps inserted through the right middle lobe bronchus reached the left hemithorax.

The left main bronchus most likely was disrupted in childhood, causing the remaining functioning lung to grow into the contralateral hemithorax, so that the chest x-ray appearance mimicked bilateral pneumothorax.

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