and remain as very useful predictors of outcome of pleurodesis. They also are helpful in predicting survival to some extent, providing us with tools to select the adequate management of our patients.

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REFERENCE


High-Resolution Computed Tomography Scan in Pneumocystis carinii Pneumonia

To the Editor:

In immunocompromised patients Pneumocystis carinii pneumonia (PCP) may present with nonspecific symptoms and the chest x-ray films may be normal or show equivocal abnormalities. Additional investigations such as pulmonary function tests and gallium scintigraphy are sensitive, but they have low specificity for PCP. A definitive diagnosis of PCP can only be made by demonstration of the organism in sputum, bronchoalveolar lavage (BAL) fluid, or a lung biopsy specimen. In case of doubt about the presence of active pulmonary disease or to indicate the optimal site for BAL or lung biopsy, computed tomography of the chest may be performed. High-resolution computed tomography (HRCT) has shown abnormalities in all HIV-positive patients with PCP, but false-negative HRCT scans have been also reported.

The specificity and sensitivity of HRCT for PCP in non-HIV immunocompromised patients are unknown. We report a 34-year-old HIV-negative patient who for 3 months before admission received immunosuppressive therapy consisting of prednisone 40 mg and cyclophosphamide 150 mg because of rapidly progressive glomerulonephritis. Two weeks before admission, he developed fever, nonproductive cough, and exertional dyspnea. Arterial partial oxygen pressure and chest x-ray film were unremarkable, but the lung carbon monoxide diffusing capacity was diminished (61% of normal). A gallium-67 scan showed diffusely increased uptake in both lungs.

The normal PaO₂ and chest x-ray film raised doubt about whether there was active (infective) pulmonary disease, and prior to bronchoscopy and BAL, a chest HRCT was performed, which appeared to be normal. The BAL fluid revealed Pneumocystis carinii, and co- trimoxazole was started. Immunosuppressive therapy was tapered to prednisone 10 mg once daily. The patient's clinical symptoms gradually diminished and fever disappeared after taking co-trimoxazole for 4 days. This case shows that HRCT scans of the chest may be false-negative in non-HIV immunocompromised patients with PCP. If there is clinical suspicion of PCP in an immunocompromised patient and radiographic and radionuclide studies show equivocal results, investigation of sputum, BAL fluid, or lung biopsy for PCP must be performed.

REFERENCES


Mycobacterium avium Complex Lung Disease in Women

To the Editor:

Dr. Wallace’s penetrating analysis of the broadening spectrum of pulmonary disease caused by Mycobacterium avium complex (MAC), which appeared in the January 1994 issue of Chest, raised three questions on which we might be able to shed some light.

First, what accounts for the demographic shift of pulmonary MAC in published reports away from a predominance of elderly white men with preexistent pulmonary disease (PEPD)—most often chronic obstructive pulmonary disease—toward elderly white women often free of PEPD?

Most reports of pulmonary MAC in HIV-negative individuals have originated in tertiary care settings where individuals with advanced and otherwise treatment-refractory disease are likely to be consigned (“tertiary care screen”). In eight reports of this type, summarized in our study, Table 2, men predominated (range, 71 to 100; median, 81%), and the percent of persons with moderate to far-advanced disease (MFAD) was high (range, 86 to 100; median, 97%). In a population-based study of 29 patients, the figures were quite different: 38% were men, and 72% had MFAD.

Furthermore, in this population, MFAD was far more likely with men than women (75 vs 17%); the gender breakdown for PEPD was identical, raising the question of whether gender might be a confounding variable for PEPD with which MFAD cases of MAC are associated. We concluded that the male predominance reported from institutional settings could be accounted for by a skewed pattern of referral, in which persons with MFAD were more likely to be selected; and the aggregation of MFAD cases among men might be attributed to their diminished ability to limit progression of established pulmonary MAC because of the structural abnormalities associated with PEPD.

Second, where does theingular-middle lobe syndrome, limited to women, fit into the pulmonary MAC spectrum?

In 1992, we reported six individuals with pulmonary MAC in

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