Incidence of Endobronchial Kaposi’s Sarcoma

To the Editor:

A recent article published in the May issue of Chest by Judson and Sahn1 provided a thorough review of endobronchial lesions occurring among HIV-infected individuals. The authors correctly point out that although endobronchial manifestations associated with HIV infection are rare, the most commonly observed form is endobronchial Kaposi’s sarcoma (EKS).

However, the authors further state that “the incidence of EKS will probably decline as the incidence of KS declines [italicized words added].” This statement is based on the data showing that the relative proportion of KS among new AIDS cases has decreased over time.2,3 In fact, this observation has been used by some to support the claim that exposure to an unknown KS cofactor of identified origin is likely to be declining.3 We have recently shown, however, that when one examines the incidence rate of various AIDS index diseases over time, the incidence of KS has remained relatively stable over the last decade.3,5 We have done so within an international registry of HIV-infected homosexual men with documented rates of seroconversion, as well as a nationwide population database in Canada. The fall in the proportion of persons with KS as a primary AIDS-defining condition is more appropriately attributed to the dramatic rise in incidence of other AIDS manifestations, eg, invasive candidiasis, cytomegalovirus infections, and Mycobacterium avium complex.

In summary, although the relative frequency of KS has decreased over time since the beginning of the AIDS epidemic, the actual incidence of this condition remains essentially unchanged.

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Digital Localization of Peripheral Lung Nodules With Video-assisted Thoracic Surgery

To the Editor:

Video-assisted thoracic surgery provides a new approach to the management of peripheral pulmonary nodules. Shepard et al1 recently studied ten patients with peripheral nodules, ranging from 2 to 15 mm subpleurally to 2-cm deep into the pleura. The patients’ nodules were preoperatively localized by a Kopsas hook wire (Cook; Bloomington, Ind), a technique originally described by Mack et al.2 Needle localization remains a useful technique for tiny nodules less than 2 mm and those located deep into the pleura. In our experience,3 however, most nodules could be localized intraoperatively by digital palpation through the intercostal incisions. Flexing the operating table to open up the patient’s intercostal spaces facilitates this procedure.4 After insertion of the thoracoscope, it must be handled carefully by the surgeon to search for the nodule. External appearance and instrument palpation often provide clues to its presence. A second intercostal incision can then be made close to the nodule; the clinician can follow the computed tomograph of the nodule if it is not visible. A third incision is then made at a distance from the other two, which results in a “triangulation” of ports, to permit proper instrument maneuvering. The collapsed lung could be brought forward to the palpating finger under thoracoscopic guidance. The combined visual and tactile feedback is familiar to the surgeon and the information obtained from one source complements the other.

Currently, we have successfully and thoracoscopically resected more than 90 peripheral nodules. We only used preoperative needle localization twice: one for a tiny nodule and the other for a deeply seated nodule. In some situations, once the stapler-cutter is applied to the lung, digital palpation can confirm the margin before firing the device. We believe that although needle localization should remain in the surgeon’s armamentarium, the surgeon’s finger remains the most useful “instrument” in this era of technologic sophistication: digital palpation can intraoperatively localize most peripheral lung nodules. In the series by Shepard et al,1 four patients who had nodules 1 cm or above, located against the pleura, and over the parietal lung surface, could probably have gone directly from the ward to the operating room without a detour.

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