bronchoscopy revealed a mass occluding the bronchus of the same lobe. *R. equi* was isolated in blood cultures, BAL, and bronchial biopsy.

Sequential antibiotic therapy—ceftriaxone, roxithromycin, rifampicin, ciprofloxacin—was not successful, and middle lobectomy was performed. Histologic sections of the middle lobe revealed a few small nodules localized in endo- and peribronchial areas. These nodules were characterized by histiocytic proliferation, with associated lymphocytes, plasma cells, and neutrophils, as well as abundant proliferative reaction. The histologic features of malacoplaia were confirmed. Moreover, the cytoplasm of histiocytes contained Gram- and Grocott-stained *R. equi*.

*R. equi*, previously classified as *Corynebacterium equi*, is an opportunist aerobic, Gram-positive bacterium that occasionally causes pneumonia in immunocompromised patients, including those with AIDS. Four other endobronchial infections due to this bacterium have been reported.1-4 All of these patients were HIV-infected, and clinical signs were progressive. *R. equi* was found in blood cultures (3 of 4) and BAL (4 of 4). Endobronchial lesions were different, but all partially or completely obstructed a segmental bronchus. Histologic features confirmed a bacterial infection and showed malacoplaia.

It may be concluded that *R. equi* in HIV-infected individuals can mimic a tumoral endobronchial process.

Isabelle Canfrere, MD, and Patrick Gérmaud, MD, Department of Pulmonology, University Hospital Laennec: Nantes; Nantes, France; and Christophe Rager, MD, Department of Pulmonology, Hospital Morlaix, Morlaix, France

REFERENCES


Use of Fiberoptic Bronchoscopy in the Diagnosis of Pleural Effusions

To the Editor:

We read with interest in the June 1994 issue of CHEST the article by R.H. Poe and colleagues (CHEST 1994; 105:1663-67) in which the authors suggest that fiberoptic bronchoscopy (FOB) is useful in diagnosing bronchogenic carcinoma in patients when there is hemoptysis, accompanying lung mass or infiltrate, atelectasis, massive effusion, or in cytology positive effusions without obvious primary tumor.

We reviewed our experience with 208 patients (3:1, male to female ratio with mean age 59±13 SD year) with pleural effusions (PE) who underwent FOB to identify those for whom the procedure was useful. Patients with nondiagnostic PE qualifying for the study were classified into two groups: (1) those with simply the isolated finding of PE (102/208=49%); and (2) those whose initial chest roentgenogram showed PE and accompanying features, eg, a lung mass, infiltrate on the chest, cavity lesion, or atelectasis (106/208=51%).

The diagnostic was bronchogenic carcinoma in 60 patients (28.5%), metastatic tumor, other than lung, in 37 patients (17.7%), parapneumonic effusion in 29 patients (13.9%), tuberculosis in 25 patients (12%), pleuritis nonspecific in 21 patients (10%), empyema in 10 patients (4.8%), no diagnosis in 10 patients (4.8%), and other causes in 14 patients (6.7%).

We established the final cause with FOB in 61 of 208 patients (29%). The diagnostic yield in the first group, those with simply finding of PE, was 2.8% (6/102) and 26.4% (55/206 patients) in the second group (PE and accompanying roentgenograms features) (p<0.001). FOB showed less diagnostic merit in the patients who had no hemoptysis (44/179). The diagnostic yield in those patients who presented with hemoptysis, however, was 58.6% (17/29), p<0.001. Bronchogenic carcinoma was the main cause of malignant PE in this series, and the diagnostic yield in such patients was 87% (53/60). Chang and Perng1 reported similar results about the role of FOB in evaluating the causes of PE.

We conclude and confirm the efficacy of FOB in those patients with PE when there is hemoptysis or other roentgenograms features such as lung mass, infiltrate, cavity lesion, and atelectasis. Although this study and another2 suggest that FOB in the absence of these indications is low and should not be routinely used.

Isabelle Canfrere, MD, and Patrick Gérmaud, MD, University Hospital Laennec: Nantes; Nantes, France; and Christophe Rager, MD, Department of Pulmonology, Hospital Morlaix, Morlaix, France

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To the Editor:

We appreciate the letter of Gámez and colleagues describing an additional experience with fiberoptic bronchoscopy (FOB) in the diagnosis of pleural effusions in a relatively large number of patients. These investigators’ observations were similar to ours. Although the diagnostic yields stated in the third paragraph are miscalculated (6/102 is 6% and 55/106 is 52%) for isolated pleural effusions and those with accompanying roentgenographic abnormalities respectively, the results compare favorably with the 12 and 50% in our study. Similar observations were recorded for patients with hemoptysis (59 vs 50% for the two studies). Our colleagues from Spain add further confirmation for a limited role for FOB in patients with pleural effusion alone.

Robert H. Poe, MD, FCCP, Paul C. Levy, MD, Robert H. Israel, MD, FCCP, Carlos R. Ortiz, MD, FCCP, and Michael C. Kallay, MD, FCCP, University of Rochester, School of Medicine and Dentistry, Rochester, New York

Communications to the Editor