the hardly contrasting new condition. Unfortunately for Dr. Kahana, the diagnosis was late, and we don’t know whether timely investigations (CT scan, fiber optic bronchoscopy, etc) at the first onset of thoracic symptoms might have changed the course. But, certainly, hemoptysis is not an underevaluated symptom, especially in smokers or former smokers > 40 years of age, even with normal chest radiographic findings, as also shown.2–4 Reporting his case, Dr. Kahana has given us the opportunity to remember that (1) former smokers are not completely risk free, even though they stopped smoking a long time ago; (2) some tumors grow slowly, may manifest dramatically after several months from the first clinical or radiographic appearance, and they cannot be readily related to lung cancer (which may, perhaps, have happened to Dr. Kahana); (3) when an incidental chest radiograph shows opacities not previously known in asymptomatic patients, especially in smokers or former smokers, lung cancer should be first suspected and further investigations carried out; (4) an apparently complete or good clinical response to antibiotic or steroid therapy should be confirmed by a radiographic follow-up; and (5) diagnostic procedures revealing doubtful results should be repeated within a short time.

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Cardiac Thrombus in Behçet Disease

To the Editor:

We read with interest the review by Mogulkoc and colleagues (August 2000) regarding intracardiac thrombus in 24 patients with Behçet disease previously published in 21 reports. It is also noted that the authors suggest a unique geographic distribution of this condition in the Mediterranean basin and the Middle East. However, several important articles2–4 from the Far East are not mentioned in the review article, although it is well-known that Japan is one of specific areas to have a high prevalence of Behçet disease. We report herein a case of Behçet disease with cardiac and pulmonary arterial thrombus from a radiologic point of view.

A 19-year-old Japanese man was admitted to our hospital in January 1996 due to hemoptysis and right heart failure. He had undergone the surgical removal of right ventricular thrombus at another hospital 9 months previously. He received a diagnosis of incomplete Behçet disease based on oral ulceration, skin lesion, uveitis, and positive human leukocyte antigen-B51. Enhanced helical CT (Fig 1, top, middle) revealed thrombus of the right atrium, right ventricle, and right pulmonary artery. Indium-111 platelet scintigraphy (Fig 1, bottom) showed strong uptakes in the right-sided heart and right pulmonary hilus suggesting acute thrombus formations. Scintigraphy clarified the activity of thrombus and contributed to determining the therapeutic strategy against the serious complications of Behçet disease.

Helical CT can be helpful in the assessment of thoracic manifestations of Behçet disease including thrombus of the systemic veins, heart, and pulmonary arteries.2 To our knowledge, there have been no reports of the use of indium-111–labeled platelet scintigraphy in cardiac thrombus in Behçet disease.1–3 Scintigraphy can be used to determine whether a thrombus is acute or chronic.6

The selection of key words for a computerized search of the medical literature using the National Library of Medicine’s MEDLINE is important. Our case and several reported cases4–5
strongly suggest that the Far East should be included among the specific geographic distribution of patients with cardiac thrombus in Behcet disease.

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Metastatic Lung Cancer Without Regional Lymph Node Swelling

To the Editor:

In order to better understand the etiology of distant metastasis with no regional lymph node swelling, a review of 891 patients with lung cancer who were admitted to our hospital from 1983 to 2000 has been undertaken. TNM staging1 was performed by chest CT, abdominal CT, head CT, or brain MRI scans, and bone scintigraphy. Clinical stage N0 was defined when neither mediastinal nor hilar lymph node measured > 1.0 cm in diameter as detected on enhanced chest CT scan.2 Thirty-one patients (3.5%) had distant metastasis with no regional lymph node swelling at the time of diagnosis. Histology included 26 adenocarcinomas (83.9%), 2 squamous cell carcinomas, 2 large cell carcinomas, and 1 small cell carcinoma. Twenty-three patients had good performance status (performance status of 0 to 1). The size of the primary lesion was not necessarily large (30 mm; nine patients). In 21 patients, metastases were confined in only one organ. The most common organs were lung, bone, and brain. Silent metastasis detected only by the imaging procedures was found in 21 patients. All these metastases detected by imaging procedures were confirmed as true-positive by following their clinical courses.

CT scan has been important and useful for evaluation of hilar and mediastinal lymph nodes in lung cancer patients. However, the reliability of diagnostic criteria for node metastasis by node size on CT scan remains controversial.3 It has been known that nonmalignant nodes may be enlarged because of reactive hyperplasia or obstructive pneumonia in squamous cell carcinoma.4 On the other hand, metastatic nodes may appear normal in size if the

FIGURE 1. Enhanced helical CT showed thrombus of the right-sided heart (top) and right pulmonary artery (middle). Bottom: Scintigraphy showed abnormal accumulations in accordance with findings on helical CT.