Communications for this section will be published as space and priorities permit. The contents should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Please include a cover letter with a complete list of authors (including full first and last names and highest degree), corresponding author’s address, phone number, fax number, and e-mail address (if applicable). An electronic version of the communication should be included on a 3.5-inch diskette. Specific permission to publish should be cited in the cover letter or appended as a postscript. CHEST reserves the right to edit letters for length and clarity.

Communications to the Editor

Catamenial Pneumothorax

Can All Cases Be Explained by the Pore Hypothesis?

To the Editor:

I read the reply of Dr. Kirschner (November 2002).1 Certainly, some of these cases seem possibly to be explained by the transpneumatic passage of gas, inasmuch as there was one patient who had been cured by a tubal ligation.2 However, since diaphragmatic defects/estimations have been found in only 19 to 33% of cases,3 and since some patients continued to show recurrent pneumothoraces after undergoing hysterecomies,4 I do not think that all cases can be explained by the pore hypothesis. Furthermore, according to this hypothesis, pneumothoraces also may occur in the nonmenstrual period since spontaneous pneumoperitoneum is one of several exceptions.5 My hypothesis is that intrathoracic free-air leaks from the lung due to focal defect(s) caused by the breakdown of the pleural endometrial tissue that has been absorbed from the stomach.

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REFERENCES


To the Editor:

I welcome the opportunity to continue the discussion of catamenial pneumothorax and the role of the diaphragmatic defects.

Again, I would like to emphasize that catamenial pneumothorax is only one of a varied host of disparate conditions in which the common denominator is a “porous diaphragm.”1 Catamenial pneumothorax is definitely linked to one aspect of endometriosis. But there are two distinct routes of spread of endometrial tissue to the thorax. The first, by far the most common, is the transperitoneal route from the pelvis to the diaphragm, which accounts for diaphragmatic pores and catamenial pneumothorax. The other, quite rare, is the hemogenous route, by which uterine endometrial tissue and/or decidua literally “metastasize” to the lung via the venous system, which drains the uterus. In latter instance, the result is the appearance of pulmonary nodules or deposits, which are clinically manifested by hemoptysis, not by pneumothorax or hemothorax. The pathologic examination of resected specimens proves them to be endometrial or decidual tissue metastatic to the pulmonary parenchyma. The monthly periodicity of catamenial hemoptysis, sometimes referred to as “vicarious menstruation,” is due to the cyclic hormonal activity of the metastatic endometrial nodule in the lung parenchyma.2,3 It does not cause catamenial pneumothorax.

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References


3 Yeh TJ. Endometriosis within the thorax: metaplasia, implantation or metastasis? J Thorac Cardiovasc Surg 1967; 53:201–205