Trees Don’t Grow in the Lungs!

To the Editor:

We read with interest a recent article on the BBC Web site of a 5-cm fir tree discovered by doctors in the lungs of a Russian botanist who underwent resection for a “lung tumor” after he presented with chest pain. The surgeon who operated on him commented that “The branch was green, as if it had just been taken from the wood. It’s still a mystery how the tree got in there.” It was thought that the patient had inhaled a seed, which is not grow in humans. To the best of our knowledge, there has never been a single report in the medical literature of seeds and/or plants growing in humans. If they did, watermelon seeds and peanuts, which are the most commonly aspirated foreign bodies, would be growing out of control from our lungs. Moreover, it makes no biological sense that in the absence of sunlight and appropriate nutrient medium, photosynthesis and germination of a seed can take place. Foreign-body aspiration often goes undetected if the initial choking episode is not obvious. In adults, a reason for the lack of acute symptoms may be the larger caliber of airways, resulting in most foreign bodies lodging in distal airways. Seeds and plant material by themselves, however, are radiolucent, and any radio-opacity seen is likely from complications. A high index of suspicion is required. A bronchoscopic examination of the airway will establish the diagnosis.

In the realm of scientific observation, the adage “trees do not grow in the lungs” indeed holds true in every sense.

To the Editor:

We read with interest a recent article (February 2009) by Dr. Craven and colleagues on ventilator-associated tracheobronchitis (VAT). In this general review, the authors elegantly discussed recent findings on the impact of targeted antibiotic therapy on patient outcomes. They outlined the difficulty in differentiating VAT from ventilator-associated pneumonia (VAP) and suggested fiberoptic bronchoscopy and CT lung scan to confirm the diagnosis of VAP. However, some clarification would be helpful for ICU physicians.

The authors stated that quantitative samples obtained from the distal airway using bronchoscopic or nonbronchoscopic lavage or specimen brush were used to confirm VAP. Do the authors