Thorax 1987;**42**:992

Correspondence

The crossover lung segment: congenital malformation associated with a variant of scimitar syndrome

SIR,—In their paper (June 1987;**42**:417–9) Drs BS Clements and JO Warner make the statement that the crossover lung segment in association with a variant of the scimitar syndrome has not previously been described but this is incorrect. Their description is, in all essentials, that of horseshoe lung.[1]

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1 Frank JE, Poole CA, Rosas G. Horseshoe lung: clinical, pathologic, and radiologic features and a new plain film finding. *AJR* 1986;**146**:217–26.

SIR,—I was intrigued by the article on the crossover lung segment (June 1987;**42**:417–9), but have a query. The three cases appear to bear a striking resemblance to the "horseshoe lung."[1,2] Is this a new syndrome or merely an old friend, albeit rare, being given a new name?

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1 Freedom RM, Burrows PE, Moes CRF. "Horseshoe" lung: report of five new cases. *AJR* 1986;**146**:211–5.
2 Frank JL, Poole CA, Rosas G. Horseshoe lung: clinical, pathologic and radiologic features and a new plain film finding. *AJR* 1986;**146**:217–26.

** These letters were sent to the authors, who reply below.

SIR,—We thank Drs Hyde and James for drawing our attention to two consecutive reports in the *American Journal of Roentgenology* on the association of horseshoe lung with scimitar syndrome. It is clear from the case description that many cases of so called horseshoe lung are, in fact, identical to our three cases, which we have described as crossover lung segments.

The essential feature of horseshoe lung is partial fusion of right and left lungs posterior to the heart. We have clear evidence in our first patient, who underwent thoracotomy, that the lungs were not fused. There was merely a segment from the upper lobe of the hypoplastic bilobed right lung lying in the left hemithorax posterior to the heart. This was not an "isthmus of pulmonary parenchymal tissue arising from the right lung base, bridging the right and left lungs posterior . . .," as described by Frank *et al*. However, the cases described by Frank *et al* and, indeed, most of the other cases reviewed by them from the reports published worldwide did not have either in vivo or postmortem thoracotomies to establish the exact anatomy. The clinical and radiological features were identical to those of our cases, demonstrating a range of features that included hypoplastic right lung, anomalous venous drainage of the right lung, systemic arterial supply to the right lower lobe, and a segment of lung parenchyma in the left hemithorax supplied by a branch of the bronchial tree and pulmonary artery from the right.

Interestingly, there is an overwhelming female predominance of this condition in the reports published worldwide (4:1), and in our patients the sex ratio was 2:1. All the other patients presented with major problems under 1 year of age and most died. Frank *et al* suggest aggressive surgical intervention with lung resection. Two of our patients have survived, one without any treatment and the other with only embolisation of the systemic arteries to the right lower lobe via a catheter. We suggest, contrary to the other publications, that, although the anatomy must be delineated, minimal surgical interference, at least in infancy, is most likely to be successful. Where there is an appreciable left to right shunt from systemic arteries to the right lower lobe via the scimitar vein, embolisation of the systemic arteries is indicated. Definitive correction may be attempted when the child is older. We also suggest that our nomenclature is more appropriate as it is clear that these patients do not have fused lungs. Indeed, conceptually, horseshoe lung is highly improbable from an embryological point of view.

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Notices

World Association of Sarcoidosis and Other Granulomatous Disorders

During the Eleventh World Congress on Sarcoidosis and Other Granulomatous Disorders in Milan in September 1987 the World Association of Sarcoidosis and Other Granulomatous Disorders (WASOG) was formed. The new association has a larger international council with worldwide representation. The first secretary general is Professor Gianfranco Rizzato, Via Juvara 9, Milan 20129. The annual membership fee is 50 000 lire (£25 sterling). New members will receive the journal, *Sarcoidosis*, a reduction in the registration fee for future conferences, and news of domestic and international meetings on granulomatous disorders. There will be a two day workshop on the structure and function of sarcoid granulomas in October 1989 in Lisbon, and a five day world congress in September 1991 in Kyoto, Japan.

Bronchitis IV International Symposium on the Dutch Hypothesis

The symposium will be held on 25–27 May 1988 in the Martini Hall Congress Centre at Groningen. The main themes of the symposium are: epidemiology of allergy and bronchial hyperreactivity, mechanisms of airflow obstruction, and therapeutic and prognostic consequences of airflow obstruction. Further information from the Congress Bureau Groningen, Postbus 72, 9700 AB Groningen, The Netherlands (tel: 50-635454/635453/635452).

Eighth Philip Zorab Scoliosis Symposium

A symposium on scoliosis will be held at the Royal Society of Medicine, London, on 26–28 October 1988. Further information from Sheila Fenton, 9–15 Aldine Street, London W12 8AW (tel: 01-740 8121).