Thorax 1989;**44**:80

Correspondence

Spontaneous pneumothorax due to metastatic carcinoma of the rectum

The paper by Mr PE Bearn and Mr OJ Lau (June 1988;**43**: 496) mentions that pneumothorax can be produced by metastasis from osteogenic sarcoma, Ewing's tumour, Wilm's tumour, melanoma, and endometrial adenocarcinoma, and that metastatic carcinoma of the rectum has previously not been reported as a cause of pneumothorax. We wish to add that various other primary malignancies, including fibrosarcoma, angiosarcoma, synovial cell sarcoma, leiomyosarcoma, etc, have also been reported to result in pneumothorax.[1] Although breakdown of the tumour directly into the pleural space, as mentioned by the authors, can result in pneumothorax, alternative mechanisms of pneumothorax formation have also been reported. These include tumour embolus and subsequent infarction and necrosis of the lung with air leak,[2] and rupture of lung tissue due to secondary deposits beneath the pleura, producing free interstitial air that may trek along the vascular sheaths to the mediastinum and rupture through the mediastinal pleura.[3] The occasional association of pneumomediastinum and the spontaneous resolution of pneumothorax in some patients strongly support the latter hypothesis of pneumothorax formation in metastatic lung disease.[1 2]

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1 Sharma S, Rajani M, Aggarwal S, Puri S, Baijal VN. Spontaneous pneumothorax and pneumodiastinum in metastatic lung disease. *Indian J Chest Dis Allies Sci* 1988;**30**:125–32.
2 Dines DE, Cortese DA, Brennan MD, Hahn BG, Payne WS. Malignant pulmonary neoplasms predisposing to spontaneous pneumothorax. *Mayo Clin Proc* 1973;**48**:541–4.
3 Spittle MF, Heal J, Harmer C, White WF. The association of spontaneous pneumothorax with pulmonary metastases in bone tumours of children. *Clin Radiol* 1968;**19**:400–3.

Bilateral empyema and purulent pericarditis due to *Haemophilus influenzae* capsular type b

Drs R Iggo and R Higgins (July 1988;**43**:582) have reported a case of bilateral empyema and purulent pericarditis due to *Haemophilis influenzae* capsular type b, stating that it was the first published case that they are aware of in this country. We have previously described a similar case of epiglottitis and pericarditis in a previously fit 26 year old woman in the UK.[1]

Our patient also developed a pericardial effusion and signs of pericardial tamponade and required pericardiotomy and drainage of the pericardial effusion. She also had no underlying immunological deficit and made an uneventful recovery.

The organism in our case was resistant to ampicillin but sensitive to chloramphenicol. The organism in the case described by Drs Iggo and Higgins was sensitive to ampicillin, but resistance of *H influenzae* type b to ampicillin has been reported at about 14%.

It is therefore important that all serious infections suspected to be due to *H influenzae* should be treated with chloramphenicol rather than with ampicillin.

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1 Mier A, Shanson D. Ampicillin-resistant *Haemophilus influenzae* epiglottitis and pericarditis in an adult. *Lancet* 1984;ii:817.

Book notice

Gastroesophageal Reflux. GG Jamieson, A Duranceau. (Pp 281; £31.) Philadelphia: Saunders, 1987. ISBN 0-7216-2319-0.

This excellent review of gastro-oesophageal reflux is essential reading for anyone with an interest in heartburn. From 5% to 10% of us are likely to experience these symptoms at some time during our lives. Apart from these personal reasons, physicians with an interest in respiratory disease should have a professional concern with gastro-oesophageal reflux. At the conclusion of their book the authors have dealt with the potential pulmonary complications of reflux, in particular bronchial asthma. The work is extensively and well referenced with work published as recently as 1987 included. The pathophysiology of gastro-oesophageal reflux is discussed in the early chapters together with clinical symptoms and diagnosis. The difficult topic of staging is covered in detail in chapter 8 and the author's reiterate the plea of Dr Ingelfinger, the father of oesophageal research, that standardised methods must be used in this area. Later chapters deal with controversial aspects of oesophageal structure, function, and management. Barrett's oesophagus is considered in detail and its malignant potential acknowledged. Schatzki's ring excites radiologists and disappoints endoscopists, but the author's review tempts me to consider active treatment of this condition. Gastro-oesophageal reflux is an important phenomenon that should concern respiratory physicians, gastroenterologists, and surgeons alike. It can cause considerable morbidity for patients. This review by Jamieson and Duranceau is clear, well written, and well worth reading and should clarify our approach to treatment.—JFM

Notice

Critical care in the 1990s congress

A congress entitled "Critical Care in the 1990s" will be held at Erasmus University, Rotterdam, from 22 to 28 April 1989. Information about invited speakers and free papers, registration, and travel arrangements may be obtained from Dr Omar Prakash, Thorax Centre, Erasmus University, PO Box 1738, 3000 DR Rotterdam, The Netherlands (tel 31-10-4635230, telex 25267, telefax 31-10-4362841).