Transcarinal needle aspiration in the diagnosis of mediastinal adenitis in a patient infected with the human immunodeficiency virus

Dr G J Serda and colleagues report that transcarinal needle aspiration is useful in the diagnosis of tuberculosis in a patient with HIV infection (May 1990;45:414–5). Needle aspiration of cervical lymph nodes has also been found to be useful in the diagnosis of tuberculosis in populations with a high incidence of tuberculosis, with or without HIV infection. We have found needle aspiration of cervical lymph nodes to be useful in the diagnosis of tuberculosis in two patients with HIV infection.

A bed-ridden, intravenous drug user, known to be infected with HIV, presented with a two week history of cough, fever, and rapidly enlarging bilateral cervical lymphadenopathy. There was no past history of tuberculosis. His sputum was smear positive for acid fast bacilli. Needle aspiration of 0·1 ml of pus from a cervical lymph node showed acid fast bacilli on the smear and grew Mycobacterium tuberculosis. A 43 year old man presented with a three month history of fever and weight loss. There was extensive cervical, axillary, and paracardiac lymphadenopathy. A clinical diagnosis of lymphoma was considered. A cervical lymph node biopsy and aspiration were performed. Smears of the needle aspirate showed acid fast bacilli, identified on culture as M tuberculosis. A subsequent test for HIV gave a positive result, though he was not in any high risk group.

In both cases a drop of needle aspirate was used to prepare smears for Ziehl–Nielson staining and cyto logical examination. The aspirate was inoculated directly on to Lowenstein-Jensen medium and the syringe and needle were flushed out with Kirschner's medium.

Lymph node aspiration is less invasive for the patient than open lung biopsy and safer for the surgeon. It is a simple and quick investigation which may provide a rapid diagnosis of infection with acid fast bacilli in HIV patients with lymphadenopathy.

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Horner's syndrome occurring as a complication of pleurectomy

There have been six recorded cases of Horner's syndrome following insertion of an intercostal chest drain (the latest having been reported by Campbell and colleagues in Thorax). We have recently seen a 19 year old woman complaining of a small right pupil and drooping of the right eyelid.

Nine months previously, while 16 weeks pregnant, she had undergone right parietal pleurectomy under general anaesthesia for recurrent right pneumothorax with the insertion of both apical and basal chest drains. Afterwards she complained of mild drooping of her right eyelid and a small right pupil but was told that this was likely to be due to the anaesthetic. These eye problems persisted after the birth of her baby and she was referred to the neurology clinic. On examination she had a mottic right pupil that was reactive to light, a very mild ptosis on the right, but no discernible enophthalmos. The diagnosis of Horner's syndrome was made. The postoperative apical chest drain had been placed at the level of the right first rib where the sympathetic chain is separated from the parietal pleura by a thin fascial layer called the endothoracic fascia (figure). This woman's Horner's syndrome was presumably caused by the apical drain pressing on the sympathetic chain and made more likely by the absence of the cushioning effect of the parietal pleura. We suggest that apical drains should be placed no higher than the third rib.

Chest radiograph showing the postoperative apical chest drain at the level of the right first rib.