

Management of bleomycin lung toxicity is frequently difficult, though steroids are widely recommended and evidence supporting their role comes from both animal studies⁶ and clinical reports on a few patients.⁵

Less settled, however, is the value of these agents in advanced bleomycin lung toxicity. Samuels and coworkers⁷ described a series of five such patients, all of whom received prednisolone in doses of 60–100 mg daily. All five died of acute respiratory failure despite this treatment. Gilson and Sahn⁸ reported a patient with bleomycin lung toxicity who developed the adult respiratory distress syndrome after surgery and ultimately responded to a combination of antibiotics and methylprednisolone 500 mg a day. Recently Hartmann and colleagues⁹ also described a patient with life threatening bleomycin lung toxicity successfully treated with methylprednisolone 1 g daily. Our case, taken in conjunction with these, suggests that severe bleomycin lung toxicity may be largely reversible provided that the treatment regimen incorporates corticosteroids in very high doses that are tapered gradually. We elected to use azathioprine in addition because of its

immunosuppressive and known steroid sparing effects.

We believe that all patients with bleomycin lung toxicity should receive a trial of corticosteroids. The dose used should depend on the severity of the pneumonitis.

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Pseudomyxoma of the pleural and peritoneal cavities

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Abstract

Pseudomyxoma peritonei is a rare clinical manifestation of mucin producing adenocarcinomas. An extensively metastasised adenocarcinoma developed a pseudomyxoma that affected not only the peritoneal cavity but also the pleura.

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Pseudomyxoma peritonei is a rare clinical entity characterised by mucinous tumour masses in the peritoneum and omentum with gelatinous ascites. It usually originates from adenocarcinoma of the appendix or ovary and less frequently from adenocarcinoma of other organs.^{1–4}

We present a patient with pseudomyxoma that affected not only the peritoneum but also the pleura.

Case report

A 41 year old farmer, a non-smoker, was admitted to hospital in December 1988 because of mild chest pain and breathlessness, clinical signs of ascites, and homogeneous shadowing in the left hemithorax on the chest radiograph (fig 1). His general condition was good. All the results of routine laboratory investigations were within normal limits.

Two and a half years earlier he had had an

acute perforation of the appendix, and he had an appendectomy at a regional hospital. The wound discharged for two months. Six months later he noticed abdominal swelling.

Abdominal ultrasound during his first admission showed massive, loculated ascites without enlargement or metastatic involvement of abdominal organs. Thoracic computed tomography showed thickened pleura and a homogeneous mass in the left hemithorax, described as “a dense pleural effusion” (fig 2). Abdominal computed tomography suggested “mucinous ascites,” partly localised around the liver, following the intestinal curve and concentrated in the pelvis.

Pleural aspiration on several occasions disclosed no malignant cells but a few were found in one sample of pleural gelatinous material. A diagnosis of adenocarcinoma was confirmed by percutaneous biopsy of the main thoracic mass.

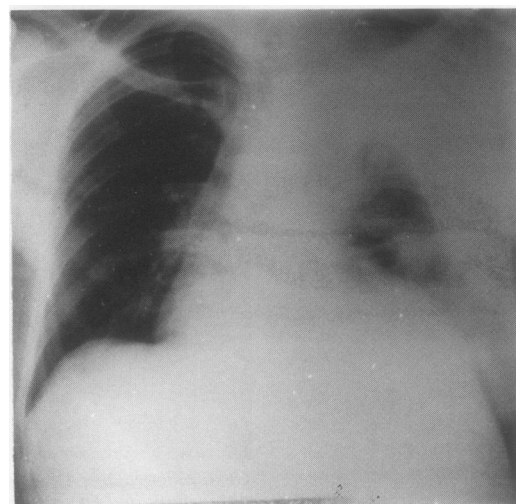


Figure 1 Posteroanterior chest radiograph: homogeneous shadowing in the left hemithorax.

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Figure 2 Thoracic computed tomogram: dense pleural effusion.



Bronchoscopy showed no abnormality.

Owing to spread of adenocarcinoma within and beyond the abdomen, surgical treatment was not indicated and he was treated with three courses of doxorubicin (Adriamycin), vincristine, cyclophosphamide, and 5-fluorouracil, but these had little effect. Thereafter the patient remained in good general condition for several months, during which he was working, though he tired more easily after hard physical work.

From August 1989 his condition deteriorated, with increasing abdominal distension, umbilical and inguinal hernias, and progressive opacification in the left hemithorax with displacement of the mediastinum to the right. At that time the patient received further cytotoxic

chemotherapy, corticosteroids, and intracavitary hyaluronidase (2000 IU) without any effect. Abdominal paracentesis evacuated only 500 ml of a gelatinous substance. Finally he developed oedema of the lower limbs and eventually died in May 1991. Necropsy was not performed.

Discussion

Pseudomyxoma peritonei was first described in 1894 and there have been reports of a few cases since then.^{1,2,4} The gelatinous material is believed to be produced by a highly differentiated mucin producing adenocarcinoma of relatively low malignancy. Treatment of the abdominal condition has included the use of various anticancer drug combinations, hyaluronidase, corticosteroids, repeated palliative surgical treatment, postoperative radiotherapy, and simple conservative treatment. The survival of patients from the time of diagnosis is over 50% at five years and one patient has survived 24 years.^{1,2,4}

The primary tumour in this case was probably in the appendix and the pleural lesion was due to metastatic spread. This has not been reported previously.

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BOOK NOTICE

Pulmonary function testing. 2nd ed. Reuben M Cherniack. Pp 316; \$24.95, £15.95. USA: Harcourt Brace Jovanovich, 1992. ISBN 0-7216-4014-1.

This pocket size, spiral bound second edition contains a concise and informative account of basic pulmonary physiology and methods of assessing function. Although it has been revised and expanded since the 1977 version there has been little substantive change, revisions to the text and figures being overall of a cosmetic nature. This new edition has three sections, starting with basic pulmonary physiology, including lung mechanics, pulmonary ventilation and circulation, control of breathing, and adaptation to exercise. The second section describes a very extensive range of pulmonary function tests and how they may be used to measure the physiological variables introduced in the first section. Each test is described in mainly theoretical terms, though the section on provocation testing, which includes oral agents, deals with practical considerations, such as dosage and timing. The final section discusses interpretation of abnormal lung function and blood gas analysis in the context of the underlying pathophysiology. The book is well laid out with a large initial glossary and key to abbreviations and symbols used. Each section is completed by a fairly basic self assessment questionnaire with answers provided in an appendix. A second appendix includes normal values for the tests described in the text, although the choice of references is something of a mixed bag and presumably reflects the personal idiosyncrasy of the author. The book is very readable, brief, and to the point without omitting vital information. It does not provide sufficient detail for the expert but is an excellent starter for the lung function technician or perhaps the physician without a detailed physiological background who finds themselves responsible for a local laboratory service.—CMR

NOTICES

Pathology courses

Three courses on pathology will be held in the spring at the National Heart and Lung Institute: (1) *advanced cardiac pathology*—the cardiac autopsy, interpreting the cardiac biopsy, recent advances in understanding the cardiomyopathies: 29 March 1993; (2) *lung tumours*—cell biology, cytology, pathology, radiology, staging, surgery, chemotherapy, radiotherapy, diagnosis, prognosis, genetics, oncogenes: 30-31 March 1993; (3) *mediastinal tumours*—pathology, radiology, diagnosis, thymomas, lymphomas, germ cell tumours, cysts, neural tumours, infections, surgery, chemotherapy: 1-2 April 1993.

For further details please contact Postgraduate Education Centre, National Heart and Lung Institute, London SW3 6LY (tel 071 351 8172; fax 071 376 3442).

Meeting on mycobacterial infections

A joint meeting of the British Thoracic Society and the Association of Medical Microbiologists on mycobacterial infections will be held on 22 April 1993 at the Institute of British Architects, 66 Portland Place, London W1N 4AD. Details from Dr PDO Davies, Tuberculosis Research Unit, Sefton General Hospital, Liverpool L15 2HE (tel 051 733 4020 ext 2062; fax 051 734 4641).

Conference on Behçet's disease

The sixth international conference on Behçet's disease will be held in Paris on 30 June and 1 July 1993 (deadline for abstracts 30 March). Details from Dr B Wechsler, Pitié-Salpêtrière Hôpital, 75013 Paris, Cédex 13 (fax 33 (1) 45 70 63 53).