

Correspondence

Localised pulmonary arteritis in rheumatoid disease

SIR,—Drs JG Armstrong and RH Steele in their report "Localised pulmonary arteritis in rheumatoid disease" (April 1982, p313) write that acute fibrinoid arteritis localised to one area of the lung has not been described previously as a manifestation of rheumatoid disease.

May we draw your attention to our publications.^{1,2} In these we described a case of a 56-year-old woman with seropositive rheumatoid arthritis and migrating pneumonia. The transthoracic biopsy revealed a necrotising angitis. The administration of corticosteroids resulted in a quick and complete cure of the pulmonary disease. We would consider this as a localised pulmonary manifestation of rheumatoid disease, although the localisation changed in the manner of a "migrating" infiltration.

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References

- 1 Meier-Sydow J, Mitrou PS, Vorbach E, Amthor M, Röttger P, Riemann HE. *Verhdt Dtsch Ges Inn Med* 1977;83:1776-80.
- 2 Meier-Sydow J, Amthor M, Mitrou PS, Riemann HE, Vorbach E. *Prax Pneumol* 1977;31:452-68.

SIR,—Unfortunately in our literature review of reports of pulmonary arteritis we did not find either of the publications to which Professor Meier-Sydow refers. We have requested copies of these publications, which are not readily available in Australia. This not withstanding, it would appear that Professor Meier-Sydow has described an acute form of pulmonary arteritis occurring in rheumatoid disease, and we know of a case similar to our own which has been observed in London. It would appear that the condition may be more common than was originally thought; and the response to corticosteroids as observed by Professor Meier-Sydow supports the need for a histological diagnosis, as we have suggested.

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Chylothorax after coronary artery bypass grafting

SIR,—Chylothorax is a rare complication of intrapericardial cardiac surgery via a median sternotomy.^{1,2} We have recently encountered such a case in a 51-year-old caucasian man who had undergone quadruple coronary artery bypass grafting through a median sternotomy and under cardiopulmonary bypass in July 1981.

The postoperative course and initial convalescence after discharge from hospital were uneventful. Two months later the patient presented to another hospital complaining of lethargy and breathlessness. A chest radiograph showed gross cardiomegaly and this was interpreted as being due to a pericardial effusion. He was admitted and one litre of whitish fluid was aspirated via the 5th intercostal space in the left anterior axillary line. Symptomatically he improved temporarily but there was no radiological change in heart size. He was referred here for pericardial drainage. On admission he looked ill and had clinical signs of a left basal pleural effusion. Chest radiography again showed cardiomegaly but a two-dimensional echocardiogram showed a left pleural but no pericardial effusion. Chest aspiration via the 6th left intercostal space revealed creamy fluid. Biochemical investigation of the fluid showed a total protein concentration of 45 g/l and microscopy showed many chylomicrons but no organisms or pus cells. A diagnosis of chylothorax was made. A chest drain was inserted in the left pleural space and connected to suction. Over the next four days 2 l of fluid were drained and then drainage stopped. The chest tube was removed. Clinically and radiographically the chest became clear and the heart size returned to normal. At follow-up six months later the patient remained well.

Chylous fistula following sternotomy is usually located in the anterior mediastinum in the region of thymic tissue, and Joyce *et al*¹ suggested that the problem may be averted by surgical ligation of thymic vascular structures instead of electrocautery at the time of dissection. There is often a latent interval, ranging from days to weeks, between operative injury and signs of leakage of chyle, during which chyle accumulates in the mediastinum and eventually tracks into either pleural space.³ The radiological appearances may be mistaken for pericardial effusion but a two-dimensional echocardiogram will be useful in differentiating the two conditions.

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- 1 Joyce LD, Lindsay WG, Nicoloff DM. Chylothorax after median sternotomy for intrapericardial cardiac surgery. *J Thorac Cardiovasc Surg* 1976;71:476-80.
- 2 Kaul TK, Bain WH, Turner MA. Chylothorax: report of a case complicating ductus ligation through a median sternotomy and review. *Thorax* 1976;31:610-6.
- 3 Higgins CB, Mulder DG. Chylothorax after surgery for congenital heart disease. *J Thorac Cardiovasc Surg* 1971;61:411-8.