

Exogenous particles in lymph nodes in patients with shrinking pleuritis with atelectasis

SIR.—I am rather surprised that Dr Dernevik (December 1985;40:948-51) uses the term shrinking pleuritis with atelectasis in preference to the more descriptive term of round atelectasis. This interesting form of lung collapse has been well described by Hanke and Kretschmar, who advocate the term round atelectasis. In 1980 they reported experience with 80 cases of this condition and pointed out its specific radiological features.¹

This benign condition is often mistaken for a bronchial carcinoma. In view of this, its recognition is of prime importance to avoid unnecessary invasive tests and thoracotomies. Since I became aware of the condition I have accumulated 10 cases over the last three years. Thoracotomy was avoided in eight patients. The remaining two each had bronchial carcinoma with pleural effusion, which resulted in the formation of the round atelectasis. In this very small series only one case was related to asbestos exposure. All except two of the others had pleural effusions.

It is advisable to consider the possibility of round atelectasis when assessing subpleural opacities, especially those seen in the lower zones of the lung fields. Awareness of this condition will prove to be beneficial.

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1 Hanke R, Kretschmar R. Round atelectasis. *Sem Roentgenol* 1980;15:174-82.

fore clear that he himself uses the term only as a description of radiological appearance and not as the name of a lesion that is distinct from carcinoma.

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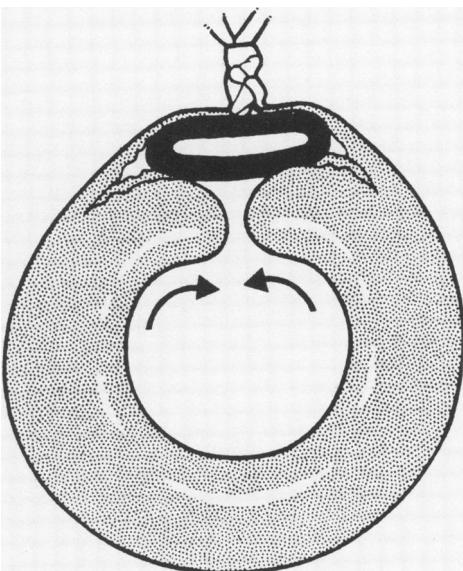
1 Dernevik L, Gatzinsky P, Hultman E, Selin K, William-Olsson G, Zettergren L. Shrinking pleuritis with atelectasis. *Thorax* 1982;37:252-8.

2 Anonymous. Case reports of the Massachusetts General Hospital. *N Engl J Med* 1983;308:1466-72.

New complication associated with the Angelchik prosthesis

Sir.—We wish to report a new complication associated with the Angelchik prosthesis. Recently a 27 year old woman presented with severe gastrooesophageal reflux resistant to medical treatment. Oesophagitis was confirmed at endoscopy and a radiotelemetric 24 hour pH study revealed frequent reflux episodes. On the fifth day after the uncomplicated insertion of an Angelchik prosthesis the patient complained of the sudden onset of severe back pain immediately after a meal and developed dysphagia. A barium swallow on the 14th postoperative day showed a dilated oesophagus with obstruction at the level of the prosthesis. Dysphagia persisted and endoscopy revealed a 2cm long narrowed segment at the cardia with apparently normal mucosa. The narrowing was dilated to 45 F on two occasions without any improvement in symptoms.

Eleven weeks after the original operation the prosthesis was removed. It was not encapsulated, and the tape and its knot were intact; but the whole prosthesis had rotated so that the knot now lay posteriorly (figure) and the



Diagrammatic representation of the findings at laparotomy performed to remove the Angelchik prosthesis.

* *This letter was sent to the author, who replies below.

SIR.—The term "rounded atelectasis" proposed by Hanke and Kretschmar has not been universally accepted. Many other terms—for example, the folded lung, pleuroma, pulmonary pseudotumour and lung folding—have been used (see reference list in an earlier paper of ours¹). This may be taken as evidence that no name has been quite satisfactory.

Most authors have given only radiological descriptions of patients believed to have the same disease even when verification by operation and pathological examination is missing. In a series with 36 cases operated on because of an undiagnosed mass in the lung, we could define pathological criteria for the diagnosis of shrinking pleuritis with atelectasis. A radiological image that could be called "rounded atelectasis" was present in only a little more than half of the cases. Thus the term rounded atelectasis is useful only as description of the radiological image in some of the patients with shrinking pleuritis with atelectasis. It is our opinion that the name of the lesion should be based on its pathology and not on its variable radiological presentation. A comment in the *New England Journal of Medicine*² can be taken as support for our opinion of the pathogenesis of shrinking pleuritis with atelectasis. The radiological diagnosis is difficult in this lesion; thus thoracotomy cannot be avoided in all patients. Dr Morcos states that two of his patients with "rounded atelectasis" had bronchial carcinoma. It is there-