

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.

* *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-

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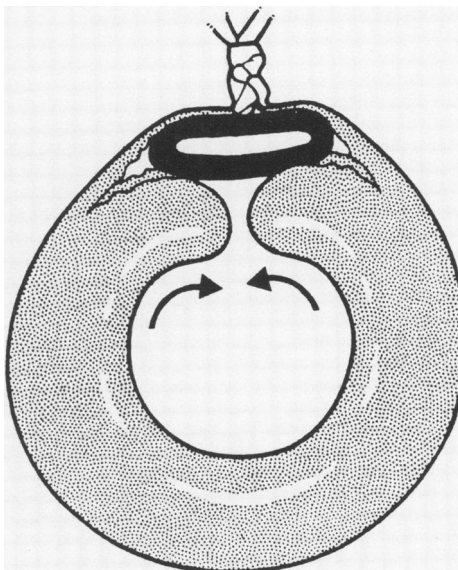
1 Dernevik L, Gatzinsky P, Hultman E, Selin K, William-Olsson G, Zettergren L. Shrinking pleuritis with atelectasis. *Thorax* 1982;37:252–8.

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.

oesophagus lay between the torn edges of the prosthesis cushions and the tape. The tape was partially torn from both ends of the prosthesis; despite this, however, the silicone of the prosthesis had not extruded. The prosthesis was removed, with immediate relief of dysphagia and pain.

The Angelchik prosthesis has enjoyed considerable popularity because of the simplicity of operative insertion, little morbidity, and good clinical results.¹ Transient dysphagia is known to occur in up to a third of patients and this may last several weeks.^{1,2} In our patient, however, dysphagia was severe and of sudden onset and was associated with back pain. The dysphagia did not respond to conservative management or endoscopic dilatation. It is postulated that the prosthesis had rotated and that the oesophagus then slipped between the ends of the prosthetic cushion. The tearing of the cushion from the tape was probably the result of the endoscopic dilatation. This complication of the Angelchik prosthesis has not previously been recorded. Rotation could perhaps be avoided by suturing the prosthesis tapes anteriorly to the diaphragm.

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- 1 Angelchik JP, Cohen R. A new surgical procedure for the treatment of gastro-oesophageal reflux and hiatus hernia. *Surg Gynecol Obstet* 1979;148:246-8.
- 2 Starling JR, Reichelderfer MO, Pellet JR, Belzer FO. Treatment of symptomatic gastro-oesophageal reflux using the Angelchik prosthesis. *Ann Surg* 1982;195:686-9.

Notices

Oxygen concentrator service

An editorial on long term oxygen therapy was published in *Thorax* in November 1985. At that time the Department of Health and Social Security had not published guidelines for the prescription and supply of oxygen concentrators in England and Wales. Guidelines have been published since and circulated to members of the British Thoracic Society, but many doctors appear to be still unaware of the existence of the guidelines or of where they may be consulted.

Details of the oxygen concentrator service are to be found in the *Drug Tariff* (which is circulated to all general practitioners and district health authorities and is likely to be available for reference in hospital pharmacies). Part X of the *Drug Tariff* contains information on the specification and supply of all forms of domiciliary oxygen. The names and addresses of the suppliers holding contracts with regional groups of family practitioner committees for the provision of oxygen concentrators are set out in section A of part X. Clinical guidelines for prescribing long term oxygen therapy are to be found in sections 4-9 of the appendix to part X. The appendix to part X is the matter previously circulated to members of the BTS.

Pharmacology of asthma

A five day course entitled "The Pharmacology of Asthma" is being held at the Cardiothoracic Institute, Brompton Hospital, London SW3 6HP, from 24 to 28 November 1986. Further details may be obtained from Professor Peter Barnes or from the postgraduate course secretary (01 352 8121 ext 4187).