



Fig 2 Computed tomography contrast enhanced scan of the thorax showing a mediastinal mass (white asterisk) posterior to and compressing the left atrium (black asterisk).

tissue. In some areas of the cyst wall the lining epithelium was absent and there was chronic inflammation.

Discussion

The occurrence of major complications from a bronchogenic cyst is uncommon and extrinsic compression of the heart appears to be quite exceptional. To the best of our knowledge this has been described in only two studies so far. Maier² reported two cases of intrapericardial bronchogenic cyst in which sudden death was attributed to pressure on the heart or great vessels, and more recently a case of bronchogenic cyst compressing the pulmonary artery and right ventricular infundibulum has been described.³ Our case is the first to be reported of a bronchogenic cyst compressing the left atrium, a condition obviously having the potential for a catastrophic haemodynamic derangement. It is noteworthy that the first clue to the presence of the cyst was the sudden paroxysm of atrial fibrillation, probably due to mechanical stretching of the atrial myocardial fibres. Our report confirms the value of two dimensional echocardiography in the diagnosis of extracardiac space occupying lesions,⁴ and illustrates its role in differentiating between a solid and a cystic mass.⁵ We conclude that left atrial compression is a possible complication of mediastinal bronchogenic cyst and that two dimensional echocardiography is an extremely valuable diagnostic tool for its early detection.

We are indebted to Dr A Maggi and Dr P A Belloni for their valuable help with the patient.

References

- 1 Fraser RG, Paré JAP. *Diagnosis of diseases of the chest*. 2nd ed. Philadelphia: W B Saunders, 1977:614.
- 2 Maier HC. Bronchogenic cysts of the mediastinum. *Ann Surg* 1948;127:476-502.
- 3 Harris M, Woo-Ming MO, Miller CG. Acquired pulmonary stenosis due to compression by a bronchiogenic cyst. *Thorax* 1973;28:394-8.

- 4 Chandraratna PAN, Littman BB, Serafini A, Whayne T, Robinson VH. Echocardiographic evaluation of extracardiac masses. *Br Heart J* 1978;40:741-9.
- 5 Pezzano A, Belloni A, Faletra F, Binaghi G, Colli A, Rovelli F. Value of two-dimensional echocardiography in the diagnosis of pericardial cysts. *Eur Heart J* 1983;4:238-46.

Notices

Tuberculosis: the forgotten disease

A grand round entitled "Tuberculosis: the Forgotten Disease" will be held at 5 pm on Tuesday 26 April 1988 in the Goldsmiths Theatre, London School of Hygiene and Tropical Medicine, London WC1E 7HT. It will consider how district health authorities should organise prevention and control programmes. The speakers are Dr K Citron, Dr RT Mayon-White, and Ms Shirley Goodwin. Admission free. Further information from Dr Martin McKee in the Department of Community Health (tel: 01-636 8636 ext 306).

Courses on current advances in laboratory techniques

Further details and application forms for the following courses are available from Professor Julia M Polak, Histochemistry Unit, Royal Postgraduate Medical School, Hammersmith Hospital, London W12 0HS. The fees are £300 (including lunch but not accommodation).

In vitro receptor autoradiographic technique, 16-20 May 1988: A course of lectures and practical demonstrations of this technique and how it is applied in analysis of the action of drugs, neurotransmitters and regulatory peptides. Topics include ligand and tissue preparation, autoradiography, quantification, localisation of binding sites at the ultrastructural level, and applications in pathology and research.

Modern immunocytochemistry, 10-14 October 1988: The theory and practice of immunocytochemical methods for light microscopy, including immunofluorescence, immunoenzyme, immunogold, and multiple labelling, with the use of direct, indirect, enzyme-antienzyme and avidin-biotin techniques. Students may work on their own projects. This course is suitable for anyone wishing to gain knowledge and practical experience in up to date immunocytochemistry.

Immunocytochemistry in cytopathology—methods and applications, 5-9 December 1988: Lectures and practical sessions on the preparation and immunostaining of whole cells in pathological specimens and cell cultures for light and electron microscopy. DNA hybridisation will be discussed, with slide review sessions. The course is suitable for pathologists, technicians, and scientists working with whole cells or cell cultures.

See also notices on p 218

Correspondence

Laser treatment for tracheobronchial tumours: local or general anaesthesia?

SIR,—We fully agree with the conclusions and recommendations of Dr PJM George and his colleagues (September 1987;42:656–60) that clinicians planning to undertake bronchoscopic laser treatment should consider a method using general anaesthesia and rigid bronchoscopy. Nevertheless, our experience in 75 patients (172 sessions) receiving bronchoscopic laser treatment for tracheobronchial lesions with a purpose designed rigid bronchoscope¹ and general anaesthesia is at variance with theirs.

In those of their patients treated under general anaesthesia, they say, “the treatments are usually completed within two hours, but can be extended for up to three hours.” None of our patients required such a long duration of treatment. The average duration of anaesthesia has been 35 minutes a session, and only exceptionally have patients required endotracheal intubation beyond this time after the completion of the treatment. We believe that (a) the long duration of anaesthesia in their patients may be responsible for some at least of their post-treatment complications and (b) that their method of using the flexible fiberoptic instrument through the rigid bronchoscope inevitably requires multiple manipulations that will unnecessarily prolong the duration of treatment and anaesthesia.

We also find that the duration of hospitalisation of the patients of Dr George and his colleagues is longer than ours, which is two to three days. Only patients referred to us from distant areas are in hospital from Monday to Saturday, in order to receive two consecutive treatments.

Finally, objective assessment of the results (response to treatment) as presented by the authors must be interpreted with caution and requires additional clarification—that is, while radiological improvement may be achieved immediately or soon after the treatment the improvement in peak expiratory flow rate, if any, is only demonstrable a few days or even a week later. Therefore the point after treatment at which these tests are carried out for comparison with the pretreatment figures is important and should be stated.

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1 Moghissi K, Jessop T, Dench M. A new bronchoscopy set for laser therapy. *Thorax* 1986;41:485–6.

* *This letter was sent to the authors, who reply below.

SIR,—While most laser bronchoscopists prefer to give treatment under general anaesthesia, the choice of bronchoscopic technique varies between different groups. Although we have no experience with the bronchoscopy set designed by Mr Moghissi and his colleagues (his ref 1), we have found that the combination of rigid and fiberoptic bronchoscopes provides greater versatility than the use of a rigid instrument alone: the Storz ventilating bronchoscope provides good airway control and excellent access for proximally situated tumours, while

the fiberoptic bronchoscope is superior for treating more peripheral tumours.

The duration of our treatments is very variable and depends on the amount of tumour within the tracheobronchial tree; treatments of two to three hours are exceptional. Mr Moghissi implies in his letter that, although his treatments last no longer than 35 minutes, more than one session may be given within a short interval. We prefer to complete treatment in one session as this minimises the overall discomfort and inconvenience to the patient. We also believe that it is important to clear as much tumour as possible from the airway in a single session as this will protect the airway from the hazards of postoperative exudation and oedema.

Clearance of exudate and resolution of oedema may account for the continued improvement in lung function which occurs during the postoperative period. In the study under discussion we performed lung function tests three to five days after treatment, and so it is possible that our results underestimated the magnitude of improvement. Unlike Mr Moghissi, however, we have found that improvements in peak expiratory flow are usually evident immediately after treatment. If we had limited our treatment sessions to 35 minutes such improvements might not have been obtained.

We agree that the duration of hospital admission is determined by both logistical and medical factors. Most of our patients (about three quarters) live outside the districts of our two hospitals and this inevitably lengthens their stay in hospital. An appreciable number are also in need of inpatient hospital care at the time of referral; many have infection distal to the obstructing tumour and some are close to asphyxiation.¹ The average hospital stay of 7.8 days that we reported in our paper does not seem unreasonable in such circumstances.

Clearly, conclusions on the relative merits of different bronchoscopic techniques cannot be based on a comparison of data obtained in unmatched groups of patients. Although objective assessments of these different techniques would be desirable, the final choice will surely remain a matter of taste for the individual.

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1 George PJM, Garrett CPO, Hetzel MR. Role of the neodymium YAG laser in the management of tracheal tumours. *Thorax* 1987;42:440–4.

Notice

Symposium in the practical management of patients with cystic fibrosis

A symposium entitled “Growing Points in the Practical Management of Cystic Fibrosis Patients” will be held on Friday 22 April 1988 at East Birmingham Hospital Postgraduate Medical Centre. Full details from Miss M C Wood, postgraduate secretary, East Birmingham Hospital, Birmingham B9 5ST (021 772 4311).

See also notices on p. 217.