Percutaneous biopsy of mediastinal tumours under sonographic guidance

In his editorial (March 1991;46:157-9) Dr K Wernecke states that sarcomas and other rare primary mediastinal tumours cannot be diagnosed accurately by percutaneous biopsy even on the basis of large tissue cylinders. I would beg to disagree with him on this issue. Large cylinders of tissue obtained with wide bore needles can be sufficient for diagnosis even of these rare lesions. There have been great advances in the application of immunocytochemical markers to aid in the diagnosis of soft tissue tumours. In addition, cell tumours can be accurately typed by means of several markers, such as human chorionic gonadotrophin, a fetoprotein, and placental alkaline phosphatase. Use of these markers can help the pathologist to come to a firm diagnosis even with formalin fixed material. Several sections can be obtained from these cylinders of tissue and the appropriate antibodies applied. We have recently been able to obtain sufficient tissue cylinders with the biopsy gun needle (Radio-plast, Sweden) from lesions in the peripheral lung to give a correct diagnosis in most cases, using both light microscopy and immunocytochemistry.

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LETTERS TO THE EDITOR

The laryngeal mask airway and flexible bronchoscopy

Dr Stephen G Spiro is taking over as Editor of Thorax on 1 October 1991. Papers being submitted to Thorax should be sent to him at the Royal Brompton National Heart and Lung Hospital, Sydney Street, London SW3 6NP.

The laryngeal mask airway and flexible bronchoscopy

I read with interest the short report by Dr J McNamee and others concerning use of the flexible bronchoscope through the laryngeal mask airway to assess a case of stridor (February 1991;46:141-2). There are several additional points I would like to make that may be of interest to your readers.

Firstly, the laryngeal mask airway does not require a patient to be anaesthetised before its insertion. At this hospital we have performed 50 uneventful diagnostic fibreoptic bronchoscopies via the laryngeal mask airway with the patient awake after preparation of the airway with topical spray and a cricothyroid puncture. In cases of severe laryngeal anaesthesia can be avoided while the airway is assessed. Secondly, the laryngeal mask airway can be used as a tool to aid intubation in those circumstances where the airway needs to be secured for tracheostomy or other management strategies. There are several techniques that have been described. A bougie can be passed blindly or under fibreoptic guidance into the trachea via the laryngeal mask airway and an endotracheal tube railroaded into position or a small endotracheal tube (size 5 cuffed or size 6 uncuffed) can be guided into the trachea fibreoptically via the laryngeal mask airway. Finally, a split laryngeal mask airway has been described, which can be peeled off a fibreoptic bronchoscope and allows a larger endotracheal tube to be railroaded into position.

The key point is that the laryngeal mask airway can assist not only in the diagnosis of laryngeal and bronchial pathology but also in its subsequent immediate management.

Confidence on asthma deaths

A conference on sudden deaths from asthma and their prevention will be held at the Royal College of Physicians, 1 St Andrew's Place, London NW1 4LE, on Wednesday 11 December 1991 (see L56). Application forms may be obtained from the organiser, Dr C Rajagopal, Department of Paediatrics, St Mary's Hospital, Newport, Isle of Wight, PO30 5TG.