deterioration to death in less than 3 months. However, with obvious radiological evidence of both intrapulmonary and pleural disease, it was important to avoid the pitfall of ascribing his respiratory symptoms to these, and failing to consider endobronchial disease. Stridor in this context should always prompt a search for a lesion in the main airway, as the advent of newer endobronchial therapies, such as stenting, brachytherapy or laser (6), may allow useful symptom palliation.

Some reports suggest better outcomes in patients treated for endobronchial metastases. The report of three patients with endobronchial metastases from sarcoma showed a moderate survival, with one patient dying 5 months after the discovery of endobronchial metastases and the other two still being alive 11 and 14 months after this finding. The present case is in stark contrast to this. The poorer outcome in this case reflects not only the extensive nature of this patient’s extrabronchial disease, but also that he had previously failed to respond markedly to aggressive chemotherapy and radiotherapy.

References

Response of dermatomyositis co-existing with non-small cell lung cancer to chemotherapy

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Introduction

Non-small cell lung cancer (NSCLC) is a common cause of death world-wide and is less responsive to chemotherapy than small cell lung cancer. Dermatomyositis is a rare condition in Chinese and is classically associated with underlying malignancy, although this association has been recently doubted by some authors (1,2). Association of dermatomyositis with lung cancer is less doubtful, although a causal relationship has not been firmly established (3). Whilst it is known that cancer-associated dermatomyositis is often more refractory to standard treatment such as the administration of systemic corticosteroids, little is known of the response of NSCLC-associated dermatomyositis to chemotherapy directed at the underlying lung cancer. The present case report describes a case of a 58-year old man who presented with dermatomyositis and was found to have extensive metastatic NSCLC. Both the NSCLC and dermatomyositis responded well to a combination of mitomycin-C (M), ifosphamide (I) and cis-platinum (P).

Case History

A 58-year old ex-smoker presented with a 2-month history of an erythematous and pruritic rash affecting his face and limbs which was resistant to topical steroid therapy (Plate 1). Deterioration and ulceration of the skin was accompanied by development of progressively disabling symmetrical limb girdle weakness (including inability to stand from sitting position and flex the neck), swallowing difficulty and weight loss, although there were no respiratory symptoms. Physical examination revealed an erythematous rash affecting the described areas, symmetrical limb girdle weakness (4/5) and nasal regurgitation, but there was no other abnormalities.

A chest X-ray showed a right hilar shadow which was revealed on thoracic computerized tomography (CT) (Plate 2) to be a 3 cm irregular mass situated anterior to the

Received 28 June 1996 and accepted in revised form 28 January 1997.

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right main bronchus. There was also ipsilateral mediastinal and contralateral hilar lymphadenopathy, and a pleural effusion. Fibre-optic bronchoscopy detected a tumour obstructing the right middle lobe bronchus, but biopsy was non-diagnostic. Thoracoscopic biopsy of mediastinal lymph nodes revealed NSCLC. Bone scan, other screening tests including liver function tests, and abdominal CT showed no other metastases. The tumour was therefore staged as III-b (T3 N3 M0).

An electromyographic study (of the deltoid and biceps) revealed myopathic changes, but the creatinine kinase level was 190 MU/l (normal 66-268 MU/l) even before chemotherapy. Muscle biopsy showed foci of mild interstitial lymphocytic infiltration with associated fibrosis, and skin biopsy showed epidermal thinning and dermal peri-vascular and peri-adnexal chronic inflammatory infiltration. Other investigations including routine biochemistry screen, auto-antibodies and plasma complement levels were normal. The patient, therefore, fulfilled the diagnostic criteria (4,5) for dermatomyositis which had no identifiable aetiology other than NSCLC.

The patient subsequently underwent palliative radiotherapy to the right lung and mediastinum (30 Gy in 10 fractions) to prevent lobar collapse. Two months following

that, he received a course of chemotherapy (four cycles each separated by 2 weeks) which was a combination of mitomycin-C (8 mg m\(^{-2}\) for 1 day at first and third cycles), ifosfamide (1250 mg for 2 days of each cycle) and cisplatinum (60 mg m\(^{-2}\) for 1 day of each cycle). Seven days after the first cycle of MIP, the patient suddenly noted complete return of his limb girdle power and ceased having nasal regurgitation. After the second MIP cycle, he reported further resolution of his rash which was not detectable after the third cycle. Thoracic CT performed 4 months after completion of MIP therapy and other screening tests revealed stable disease (defined as a lack of progression of tumour size and extent, and no further metastases). Mild generalized thickening of the skin was noted 8 months after the initiation of MIP, which progressed very slowly and was accompanied by CT evidence of enlargement of mediastinal, and appearance of axillary lymph nodes. At the time of writing, 25 months after the initiation of MIP therapy, the patient had remained otherwise well and been free of respiratory symptoms.

Discussion

Despite classical description, there is still controversy on whether or not there is a casual relationship between dermatomyositis and underlying cancer (1,2). As the muscle and skin histological features in dermatomyositis are indistinguishable, irrespective of the underlying aetiology (3), dermatomyositis may, therefore, be a homogenous disease which only occurs coincidentally with malignancy. Lung cancer can present in a variety of para-neoplastic neuromuscular syndromes including muscle atrophy, necrotobiotic myopathy and Lambert-Eaton syndrome (3). Dermatomyositis is a rare disease in Chinese (6) and is usually associated with nasopharyngeal carcinoma (6). Little is known of the response of dermatomyositis to anti-cancer chemotherapy, nor has there been a definitive casual relationship between lung cancer and dermatomyositis.
Patients with lung cancer usually have little chance of curative treatment and have a poor prognosis. Most lung cancers are of the NSCLC type, and a small but significant proportion of these patients may benefit from cis-platinum-based poly-chemotherapy in terms of survival and symptom palliation (7). A combination of mitomycin-C, ifosphamide and cis-platinum has been shown to give a response rate in 28–39% of NSCLC patients (8,9). By using a similar regime described in this case report, a response rate of 53% has been observed in Hong Kong (10). The patient described in this case report has demonstrated stable NSCLC with excellent palliation from MIP chemotherapy.

Dermatomyositis associated with malignancy is often refractory to standard treatment such as systemic corticosteroids. It has been shown that some of these resistant cases may be more responsive to α-globulin, azathioprine, chlorambucil, methotrexate, cyclosporine and cyclophosphamide (11). The response of dermatomyositis to the constituents of the MIP regime has not been reported previously although these cytotoxic drugs might have also exerted some immunomodulating effects. The similarity between cyclophosphamide and ifosphamide might also explain the efficacy of the MIP regime on the dermatomyositis, although altogether only eight doses of ifosphamide had been given. Alternatively, the regression of the dermatomyositis might have been the result of palliative radiotherapy. The improvement of dermatomyositis had been sustained until CT evidence of disease progression, and it is, therefore, highly probable that the improvement of dermatomyositis was due to the control of the underlying NSCLC by the chemotherapy regime. This constitutes good circumstantial evidence for a causal association between NSCLC and dermatomyositis. The authors' experience on this case suggests that intensive chemotherapy for underlying lung cancer may offer excellent palliation for dermatomyositis associated with lung cancers.

References


Lung abscess with squamous epithelial lining

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Introduction

A case of an epithelialized lung abscess in a patient with non-Hodgkin's lymphoma and chronic chest infection is reported. The patient expectorated pulmonary abscess membranes lined with squamous epithelium and a parakeratotic plug during thoracocentesis.

Case Report

In April 1993, a 52-year-old man was admitted with fever. The patient was known from many previous admissions with non-Hodgkin's lymphoma which had developed into paraproteinaemia and hyperviscosity syndrome treated with plasmapheresis, prednisolone and cyclophosphamide.

In 1991, the patient had presented with fever. An air-fluid interface was apparent in one and later in two cavities in the right lung on the chest radiographs. He was treated unsuccessfully with antibiotics. Repeated thoracocentesis and bronchoscopic drainage both failed to accomplish a cure.