Heerfordt syndrome

Sir,

I read with interest the article by Marie and colleagues. The authors cite that parotiditis in sarcoidosis is Heerfordt syndrome, I disagree. Heerfordt syndrome or uveoparotid fever was first described in 1909 by Christian Frederik Heerfordt, a Danish ophthalmologist, 1871–1953. Such syndrome consists of fever, parotid gland enlargement, anterior uveitis and facial nerve palsy.

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Iatrogenic gastrothorax mimicking a pneumothorax

Sir,

A 50-year-old male never smoker was admitted to hospital with lower back pain, cough and dyspnoea on exertion. On examination air entry was significantly reduced in the right hemithorax and the percussion note was hyperresonant; blood pressure was normal, although a tachycardia of 100 beats per minute was present. His past medical history included palliative tri-incisional oesophagectomy for squamous cell oesophageal carcinoma 1-year earlier. On admission, the chest radiograph (Figure 1) suggested a shallow right-sided pneumothorax and opacification within the right mid and lower zones. A subsequent right-sided pleural tap (using a small calibre needle) in the ‘safe triangle’ resulted in aspiration of digested foodstuffs. Subsequent computerized tomography scanning showed gross distension of his intrathoracic stomach secondary to gastric outlet obstruction from tumour recurrence and bony, pleural, liver and peritoneal metastasis; a pneumothorax was not identified.

Tri-incisional oesophagectomy is a three stage surgical procedure used most frequently for attempted resection of oesophageal carcinoma. During the procedure the stomach is pulled into the thorax and joined to the oesophageal stump creating a neo-oesophagus. Although our patient had no cardiovascular compromise, tension gastrothorax has been reported to cause cardio-respiratory distress and mimic a tension pneumothorax with immediate enteral tube decompression, the usual treatment of choice. This case adds to the paucity of

Figure 1. Chest radiograph showing right-sided gastrothorax.
literature illustrating that an iatrogenic gastrothorax can easily mimic a shallow pneumothorax and emphasizes the importance of appreciating abnormal intrathoracic anatomy in patients who have undergone upper gastro-intestinal surgical procedures, especially oesophagectomy. Moreover, it also reminds clinicians of all specialities and experience that further radiological imaging—prior to needle aspiration or chest tube insertion—is necessary when uncertain or unusual chest radiograph appearances are present.

Conflicts of interest: None declared.

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