LETTERS TO THE EDITOR

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.[1] In addition, germ cell tumours can be accurately typed by means of several markers, such as human chorionic gonadotrophin, α fetoprotein, and placental alkaline phosphatase.[2] 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 biopty gun needle (Radioplast, Sweden) from lesions in the peripheral lung to give a correct diagnosis in most cases, using both light microscopy and immunocytochemistry.[3]

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1 Enzinger FM, Weiss SW. Immunocytochemistry of soft tissue lesions. In: Enzinger FW, Weiss SW, eds. *Soft tissue tumours*. St Louis: Mosby, 1988:83–101.
2 Gatter KC, Falini B, Mason DY. The use of monoclonal antibodies in histopathological diagnosis. In: Anthony PP, McSween RNM, eds. *Recent advances in histopathology*. Vol 12. Edinburgh Churchill-Livingstone, 1984: 35–67.
3 Allen CM, Hansell DM, Sheppard MN. Percutaneous biopsy of parenchymal lung lesions using a biopty gun. *J Pathol* 1991;164:349A.

AUTHOR'S REPLY We are grateful for Dr Sheppard's critical remarks concerning our statement that "sarcomas and other rare primary mediastinal tumours cannot be diagnosed accurately by percutaneous biopsy even on the basis of large tissue cylinders." This statement is based on current reports[1] and on our personal experience. We agree with Dr Sheppard that there have been great advances in the application of immunocytochemical markers.[2] No data, however, are available as yet regarding the diagnostic advantages of these new immunocytochemical methods for percutaneous biopsy material from mediastinal tumours.

In Hodgkin's lymphoma no improvement can be expected with immunocytochemical markers as the diagnosis is essentially dependent on the presence of Reed-Sternberg cells. The diagnosis of non-Hodgkin's lymphoma is also complicated by sampling errors, as the nodes contain large areas of non-neoplastic lymphocytes. In theory, immunocytochemical techniques may assist in the diagnosis of thymomas (evidence of epithelioid structures with cytokeratin-IH). The same holds true for the rare thymic carcinoid (use of neuroendocrine markers). Several immunocytochemical markers have also been described for sarcomas (rhabdomyosarcoma: actin, desmin; fibrosarcoma: vimentin; histiocytoma: lysocym; neurosarcoma: P100), which could improve diagnosis from percutaneous biopsy specimens.

These theoretical ideas, however, regarding the value of immunocytochemical markers for the diagnosis of sarcomas and other rare mediastinal tumours from biopsy cylinders require further evaluation in clinical trials.

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1 Weisbrod GI, Lyons DJ, Tao LC, Chamberlain DW. Percutaneous fine-needle aspiration biopsy of mediastinal lesions. *AJR* 1984; 143:525–9.
2 De Lellis RA, ed. *Advances in immunohistochemistry*. New York: Raven Press, 1988.

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.[1] In cases of severe stridor general 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.[2,3] 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.

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1 Brimacombe J. The laryngeal mask airway—use in awake fibre-optic bronchoscopy. *Anaesth Intens Care* (in press).
2 Chadd GD, Ackers JW, Bailey PM. Difficult intubation aided by the laryngeal mask airway. *Anaesthesia* 1990;45:1015.
3 Brimacombe J, Johns K. A modified intravent laryngeal mask airway to assist fibre-optic orotracheal intubation. *Anaesth Intens Care* (in press).

NEW EDITOR OF *THORAX*

Dr Stephen G Spiro is taking over from Professor Anne Tattersfield 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.

NOTICES

Update courses in cardiopulmonary pathology

Two "update in cardiopulmonary pathology" courses will be held at the National Heart and Lung Institute. The first, on cardiology (congenital heart disease, cardiomyopathies, innervation, and conduction defects), will be on 26 and 27 March 1992 (course organiser Professor R H Anderson); and the second, on lung tumours (cell biology, pathology, radiology, staging, surgery, chemotherapy, radiotherapy, terminal care), will be on 6 and 7 April 1992 (course organiser Dr M Sheppard). Further details from the Postgraduate Education Centre, National Heart and Lung Institute, London SW3 6LY (tel: 071 351 8172, fax: 071 376 3442).

Conference 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 (fee £25). Application forms may be obtained from the organiser, Dr C Rajagopal, Department of Paediatrics, St Mary's Hospital, Newport, Isle of Wight, PO30 5TG.