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6/8/58728

Fetal thoracentesis for cystic adenomatoid malformation of the lung

To the Editors: We read with interest the article by Obwegeser et al. (Obwegeser R, Deutinger J, Bernaschek G. Fetal pulmonary cyst treated by repeated thoracocentesis. Am J Obstet Gynecol 1993;169:1622-4) in which serial thoracenteses were performed in a fetus with cystic adenomatoid malformation of the lung complicated by displacement of the heart and hydrops. We cared for a similar fetus who was noted at 25 weeks 5 days of gestation to have macrocystic structures in the chest with cardiac compression and hydrops. Amniocentesis revealed a normal male karyotype. An initial thoracentesis was performed at 28 weeks' gestation; 110 ml of clear fluid was aspirated from the pulmonary cysts, which appeared almost completely collapsed at the end of the procedure. We therefore assumed the cysts were connected. The cardiac compression was also greatly reduced. The hydrops, however, never resolved in spite of two additional thoracenteses performed at 29 weeks 5 days and 31 weeks 5 days, respectively, for reaccumulation of cystic fluid and cardiac compression. Forty and 60 milliliters of amber fluid were removed at the two procedures. A therapeutic amniocentesis for symptomatic polyhydramnios was also performed at 28 weeks' gestation. Nonetheless, the patient's course was complicated by recurrent preterm labor and chronic abruptio placentae, and at 32 weeks' gestation an emergency cesarean delivery was performed for fetal bradycardia. The amniotic fluid was grossly bloody and the placenta was noted to be almost completely separated. The neonate weighed 2680 gm and could not be resucitated. An autopsy confirmed cystic adenomatoid malformation of the lung, type I. In addition, pulmonary hemorrhage and cerebral infarcts were noted. The distribution of the infarcts were suggestive of an embolic event. Whether these aberrations resulted from the underlying anatomic abnormalities or from the invasive procedures cannot be ascertained. However, these findings disappointingly suggest that serial thoracenteses may not improve the outcome in some fetuses with cystic adenomatoid malformation of the lung complicated by hydrops and may possibly cause harm. The author's statement that decompression of the heart is both diagnostic and prognostic may not be entirely true. The observation that the hydrops did not resolve in spite of what appeared to be cardiac decompression seemed most predictive in this case.

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Reply

To the Editors: We appreciate the interest of Parilla and Chen in our paper.

They report a case with macrocystic structures in the chest with cardiac compression and hydrops. In their case hydrops never resolved in spite of three thoracenteses.

We stated in our paper that the first thoracentesis is a therapeutic and a diagnostic procedure. In case hydrops does not resolve, instead of a second thoracentesis, the application of a thoracoamniotic shunt should be considered. Because hydrops did not resolve in the reported case, our primary statement is confirmed, that the first thoracentesis is not only therapeutic but also diagnostic.

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6/8/59766

Unusual ultrasonographic appearance of uterus in postmenopausal patients receiving tamoxifen

To the Editors: We read with interest the article by Goldstein (Goldstein SR. Unusual ultrasonographic appearance of the uterus in patients receiving tamoxifen. Am J Obstet Gynecol 1994;170:447-51). We note his confirmation of our previously published finding of false ultrasonographic appearance of endometrial neoplasia in postmenopausal women treated with tamoxifen.[1] These abnormal uterine sonograms are not seldom observed. Thickened endometria with no tissue obtained on curettage may be encountered in as many as 70% of asymptomatic postmenopausal patients receiving tamoxifen.[2, 3] Our later experience has been that almost 90% of tamoxifen-treated patients who have an abnormal uterine sonogram will display this phenomenon.

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