

Lactobacilli and pleuropulmonary infection

Serious infections due to lactobacilli have been rarely reported [1, 2]. The most common clinical syndromes are endocarditis and sepsis arising from localized infection. Recently we published the first case of pneumonia caused by *Lactobacillus* sp [3]. To date only two other cases of pleuropulmonary infection have been published [4]; an empyema and a pneumonia with a concomitant non-related lactobacillaemia.

After our first report we have seen two more cases of *Lactobacillus* empyema. The first case is a patient with a squamous carcinoma of the oesophagus, in whom the insertion of a prosthesis was the origin of a pleuroesophageal fistula that caused an empyema; culture of the pleural exudate yielded *Lactobacillus* sp and *Bacteroides distansonis*. The second case is a patient with hepatic cirrhosis who required surgical therapy for oesophageal variceal bleeding. After the surgical procedure a chest film showed a pleural effusion. Thoracentesis evidenced an empyema, and *Lactobacillus* sp and *Pseudomonas aeruginosa* were identified in the culture. In this patient the hypothetical pleuroesophageal fistula could not be proven with an oesophagogram.

The first case is very similar to the one we published recently [3]; here an oesophageal carcinoma was also the origin of the pleurointestinal fistula. The fistula between the gastrointestinal tract and pleura was responsible for the empyema. *Lactobacillus* in the two cases was isolated from cultures of pleural fluid. The second case reported is different but a surgical procedure on the gastrointestinal tract was the hypothetical origin of the fistula to the pleural cavity.

The case of empyema reported by SHARPE [4] was a 64 year old man who had had a previous operation for a hiatus hernia. A fistula from the stomach to the pleural space through the diaphragm was the origin of the empyema. Considering the four cases of empyema, the one reported by SHARPE and three of ours, it seems that a direct communication through a fistula between the

gastrointestinal tract and pleura or lung must exist for the establishment of infection by *Lactobacillus* sp.

Lactobacilli are usually sensitive to penicillin, ampicillin and co-trimoxazole [5, 6] but in two of our cases the strains were tolerant to clindamycin and co-trimoxazole and the third was tolerant to co-trimoxazole and tetracycline.

References

1. Bayer AS, Chow AW, Betts D, Guze LB. - Lactobacillemia - report of nine cases. Important clinical and therapeutic considerations. *Am J Med*, 1978, 64, 808-813.
2. Davies AJ, James PA, Hawkey PM. - *Lactobacillus* endocarditis. *J Infect*, 1986, 12, 169-174.
3. Querol JM, Manresa F, Izquierdo J, Císnal M. - *Lactobacillus* pneumonia in a patient with oesophageal carcinoma. *Eur Resp J*, 1989, 2 (6), 589-591.
4. Sharpe ME, Hill LR, Lapage SP. - Pathogenic lactobacilli. *J Med Microbiol*, 1973, 6, 281-286.
5. Bayer AS, Chow AW, Concepcion NF, Guze LB. - Comparative *in vitro* activity of five cephalosporins against lactobacilli. *Antimicrob Agents Chemother*, 1979, 16 (1), 112-113.
6. Bayer AS, Chow AW, Morrison JO, Guze LB. - Bactericidal synergy between penicillin or ampicillin and aminoglycosides against antibiotic-tolerant lactobacilli. *Antimicrob Agents Chemother*, 1980, 17 (3), 359-363.

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Questionnaire of the ECSC on respiratory symptoms

The 1987 update of the 1962 and 1967 questionnaires (European Respiratory Journal 1989, 2, 165-177) is to be welcomed for the anomalies which have been sorted out and for not making any radical change, such as has damaged the 1986 MRC questionnaire [1]. However, there are several features which in our view should be restored; first, question 18 on wheeze. The new version

does not distinguish between wheeze occasionally and on most days, yet this has proven most helpful in our studies of shipyard workers amongst whom the decrement of lung function associated with "wheeze occasionally" is, on average, about half that which accompanies wheeze on most days [2]. The circumstances in which wheeze usually occurs are also in our view informative,

as do the ATS which distinguishes between wheeze with colds and at other times [3]. Second, previous chest illness (question 26, d); this no longer contains a check list to remind the subject of illnesses which might otherwise be forgotten. In our experience, the failure to supply a list leads to the giving of false negative replies. This could be important because a history of pneumonia or pleurisy are both associated with some loss of lung function even in the absence of respiratory symptoms [2]. Third, smoking questions. The omission of the question on whether or not a person inhales is probably of no consequence for the average male cigarette smoker. It is important for female cigarette smokers and for cigar and pipe smokers; some persons in these categories inhale to the detriment of their chest whilst others do not and failure to make the distinction could restrict data analysis unnecessarily. An additional restriction is the failure to record the month and year, instead of age, at which an ex-smoker finally gave up. Without the additional information it is in some circumstances impossible to decide if a person is an ex-smoker according to an exact definition, or merely a short-term abstainer.

We believe these omissions detract from the usefulness of the questionnaire and very much hope they will be restored. This is particularly important if the use of

the questionnaire is to be made mandatory for ECSC grant holders. We hope this will not be the case for circumstances where an alternative would be more appropriate.

References

1. Cotes JE. – Medical Research Council Questionnaire on respiratory symptoms (1986). Correspondence. *Lancet*, 1987, 2, 1028.
2. Cotes JE, Feinmann EL, Male VJ, Rennie FS, Wickham CAC. – Respiratory symptoms and impairment in shipyard welders and caulker/burners. *Br J Industr Med*, 1989, 46, (in press).
3. Helsing KJ, Comstock GW, Speizer FE, *et al.* – Comparison of three standardised questionnaires on respiratory symptoms. *Am Rev Respir Dis*, 1979, 120, 1221–1231.

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Epidermal growth factor receptors

Slebos and Rodenhuis in their excellent review of the molecular genetics of lung cancer (*Eur Respir J*, 1989, 2, 461–469) pointed out the need for information on the clinical behaviour of lung cancers expressing epidermal growth factor (EGF) receptors. We wish to draw to your attention our study [1] showing that immunoperoxidase staining with the R1 antibody to the EGF receptor is significantly stronger on lung tumours than normal lung tissue. Furthermore, we found that the staining in 40 squamous tumours was significantly stronger than for other non-small cell cancers and there was stronger staining in 30 stage 3 non-small cell lung cancers compared to 47 stage 1 and stage 2 tumours, as classified by the TNM classification. Since the stage of tumour at presentation is of prognostic significance, we feel that the degree of EGF receptor expression on non-small cell lung cancers may be of predictive value in these tumours.

References

1. Veale D, Ashcroft T, Marsh C, Gibson GJ, Harris AL. – Epidermal growth factor receptors in non-small cell lung cancer. *Br J Cancer*, 1987, 55, 513–516.

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Corrigendum

Peak flow records in asthma: evaluation of an algorithm for interpretation of patterns. V. Bellia, F. Cibella, A. Visconti, G. Peralta, G. Cuttitta, A. Trizzino, G. Giannone, G. Bonsignore. *Eur Respir J*, 1989, 2, suppl. 6 532s–535s. Figures 2 and 3 were inadvertently transposed during printing. They should be reversed for correct order to match the legends.