There was no histologic evidence for tumor at the resection site, nor were any nodes found to contain tumors. Four weeks after surgery, the patient had a bronchoscopic examination because of a persistent cough. Resection site was normal except for a pool of mucoid secretions at the surgical stump which were positive for BAC cells. A chest x-ray film failed to show any parenchymal disease.

Two months after surgery, the patient again presented with a persistent cough and bronchorrhea. A chest x-ray film (Fig 2) showed left lower lobe consolidation. Bronchoscopic examination and bronchoalveolar lavage of the left lower lobe now showed BAC cells. A CT of the chest again confirmed absence of mediastinal nodal enlargement and no parenchymal disease was seen in the right lung. Patient underwent thoracotomy and surgical resection of the left lower lobe, which showed extensive BAC. Three months later, the patient presented with progressive dyspnea and cough productive of large amounts of mucoid expectoration. A chest x-ray film (Fig 3) confirmed the presence of consolidation of the right lower lobe. A bronchoscopic examination of the right lower lobe confirmed the presence of BAC cells. The patient died 2 months later.

This experience vividly exemplifies endobronchial spread of BAC carcinoma with direct parenchymal seeding and confirms the observations by Donovan et al.[1]

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Endobronchial Lipoma

Computed Tomography and Magnetic Resonance

To the Editor:

Endobronchial lipoma is a rare benign neoplasm that may cause irreversible pulmonary damage, and may be misdiagnosed clinically as a bronchial adenoma or a malignant lesion. The diagnosis was rarely made preoperatively until the first report on computed tomography.[1] We present a case of endobronchial lipoma diagnosed by CT and magnetic resonance (MR).

A 46-year-old man was admitted with right chest pain and occasional hemoptysis for 1 month. He smoked one pack of cigarettes a day. Physical examination was remarkable only for decreased breath sounds from the right lung and fever. The complete blood count showed leukocytosis with a left shift. Collapse of the right middle and lower lobes was seen in chest radiography. The CT scans showed a fatty mass (69 HU) that completely filled the lumen of the intermediate bronchus. The MR was performed using a 0.5 Tesla (MR Max Plus, General Electric). The T_1-weighted axial and coronal images showed the mass to be similar in signal intensity to the mediastinal fat (Fig 1). Bronchoscopic examination was performed and revealed a polypoid mass completely filling the lumen of the intermediate bronchus. An endoscopic biopsy revealed lipoma and the patient was treated with endobronchial photocoagulation by laser.

Endobronchial lipoma most often occurs in middle-aged smokers. They are usually located within the larger bronchi and

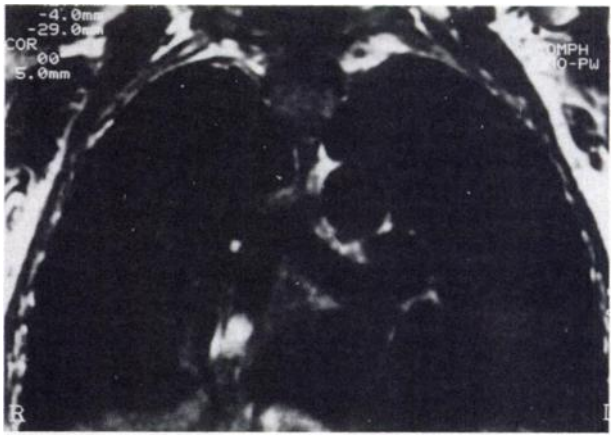

FIGURE 1. The MR scan shows on T_1-weighted coronal image—an endobronchial mass with highly hyperintensity signal (similar to the signal of mediastinal fat).

the symptoms are a result of obstruction of the airway. Most intrabronchial lipomas are pediculated and consist mainly of histologically normal adult fat cells in the peribronchial and submucosal tissue. The presence of a capsule and atypical cells due to the effects of chronic irritation, may make endoscopic bronchial biopsies erroneous or nondiagnostic.[1]

A correct preoperative diagnosis may prevent lobectomy or pneumonectomy. Chest radiography usually shows lobar collapse, consolidation, or bronchiectasis. The CT findings of a homogeneous mass with fatty density and no tumor contrast enhancement are considered diagnostic.[1,2] Only a few reports have described the MR appearance of lipoma, and our case is the first one of an endobronchial lipoma documented by MR. Lipomas have a high signal intensity on T_1-weighted images and intermediate signal intensity on proton density and T_2-weighted images, similar to normal fat. Differential diagnosis in these sequences should be established with old hematomas, calculated relaxation times or chemical shift imaging may differentiate between both.[3]

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Deaths From Bacteremic Pneumococcal Pneumonia

To the Editor:

The March 1993 issue of *Chest* contained both an original pa-

Table 1—*Clinical Features of 24 Fatalities Occurring in 96 Cases of Bacteremic Pneumococcal Pneumonia*

	Severity of Chronic Diseases				
	Rapidly Fatal	Critically Ill	Ultimately Fatal	Non-Fatal	Total
Total patients	13	3	2	6	24
Male/female	8/5	2/1	1/1	3/3	14/10
Ages					
18-44 yr	1	0	0	0	1
45-64 yr	3	2	0	2	7
>64 yr	9	1	2	4	16
Deaths by					
Day 2	7	2	1	3	13
Day 5	9	3	1	5	18
Discharge	13	3	2	6	24
Diseases present					
Cardiac	2 (1)*	2 (1)*	1	1	6
Respiratory	6 (2)*	0	2	4	12
Diabetes mellitus	2	1	0	0	3
Liver	2	2 (2)*	0	1	5
Renal	2	1	0	1	4
Malignancy	8 (8)*	0	1	0	9
Alcoholism	0	2	0	2	4
Systemic lupus erythematosus	1 (1)*	0	0	0	1
AIDS	1 (1)*	0	0	0	1

*Numbers in parentheses refer to the number of patients where this condition was primarily responsible for the severity rating.

per[1] and an editorial[2] on bacteremic pneumococcal pneumonia. In a recent publication,[3] we reported a mortality rate of 23 percent for bacteremic pneumococcal pneumonia in our institutions. Subsequently, an extended and more detailed investigation was made which may be of interest to your readers.

The definition of terms, methods used, and descriptions of the healthcare facilities involved have been published[3] previously. Extending the original study to 5 years (1984-1989), it identified 96 pneumococcal pneumonia cases that fulfilled the requirements in your publication[1] except for serotyping which was not performed. The detailed results listed in Table 1 can be compared with those published[1] in *Chest*.

Chart review made it apparent that the severity or stage of the chronic diseases present was a very significant factor. To assess this, the McCabe and Jackson[4] classification used for Gram-negative bacillary bacteremia was modified. "Rapidly fatal" referred to patients with a life expectancy of days or weeks. In our data, most of these were palliative care patients admitted with endstage disease. Blood cultures were not indicated but were taken by the emergency room physician or housestaff before the complete medical history and patient's wishes were known. "Critically ill" referred to patients with severe but not irreversible conditions where the prognosis was guarded but not hopeless. "Ultimately fatal" referred to situations where the prognosis was measured in terms of months or at best a few years. "Nonfatal" included patients not classified by the other categories.

Examination of Table 1 shows a mortality rate of 24 (25 percent) for 96 patients similar to the experience in Huntington. Over half, 13 (54 percent), occurred in the rapidly fatal group. Excluding all of this group from the study results in a mortality rate of 11 (13 percent) in 83 patients. The Stockholm experience is based on patients seen by infectious disease departments. Did their series include patients terminally ill with other conditions or are most of their admissions in the nonfatal group?

One reason for calculating mortality rates is to find ways of improving them. In this regard, the rapidly fatal group should not be counted as most did not desire treatment. A review of our nonfatal group revealed that four of the six subjects had chronic lung disease. Three subjects died of fulminating pneumonia within 24 h of admission and the fourth died of respiratory failure on day 5. The two remaining patients were alcoholics that died on days 3 and 4 of multiorgan failure and pneumonia. These findings suggest that the only way the fatality rate will be improved is by prevention of pneumococcal pneumonia in patients with lung damage and the prevention of complications during treatment.

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Factitious Hemoptysis and Anemia

To the Editor:

The report by Daily et al[1] of factitious anemia induced by self-bloodletting is of great interest. We report a case of factitious anemia with feigned hemoptysis induced by self-bloodletting.

A 21-year-old man was admitted to our hospital because of recurrent hemoptysis. His hematocrit was 20 percent, and his hemoglobin level was 6.9 g/dl. The findings from chest radiography, bronchoscopy, gastroscopy, and otorhinolaryngologic examination were normal after hemoptysis. Physical examination showed multiple injection scars in a left elbow vein. After hemoptysis a nurse found a bloody syringe and an injection needle in his bag. He confessed that he spat blood obtained by self-induced phlebotomy. After psychiatric therapy, he gave up self-bloodletting and the anemia improved.

Most self-bleeders are young, female, and in paramedical or nursing occupations.[2,3] This case demonstrates a rather unusual form of factitital illness. Psychiatric consultation is mandatory in the treatment of all patients with suspected factitious illness. Great caution must be exercised when confronting patients with evidence of the factitious nature of their illness.

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