We read with great interest the case report of a 53-year-old man with dysphagia, anorexia, and night sweats by Ferguson and Schwarz in a recent issue of CHEST (November 2010).[1] We believe a few issues need to be addressed after going through this report.

Although a diagnosis of TB was confirmed on sputum cultures, coexistence of a concomitant pneumoconiosis (eg, silicosis in this case) cannot be ruled out because there is a history of exposure to the cement industry. Silicotuberculosis is a well-described entity in literature, and it is said that silicosis increases the predisposition toward TB.[2] The parenchymal nodules on chest radiograph and diffuse miliary pattern with mediastinal lymphadenopathy on CT scan described in this patient can be associated with silicosis.[3] In this patient, the miliary shadows could be present because of preexisting silicosis and right upper lobe infiltrate because of superadded TB infection. Flexible bronchoscopy (transbronchial lung biopsy and BAL) or, preferably, open lung biopsy might have helped to rule out concomitant silicosis in this case.[4] Patients with silicotuberculosis may have resistance to antitubercular medications, and they may need a longer duration of treatment as compared with TB alone[5]; hence, it is important to recognize concomitant silicosis in the context of this case report.

Pleuritic chest pain and pericardial effusion on echocardiogram suggest the diagnosis of pericardial TB, but the authors did not mention this in their final diagnosis. Moreover, steroids should have been added for treatment of pericardial TB in addition to standard anti-TB regimen.[6]

REFERENCES:

1 Ferguson JH, Schwarz MI: A 53-year-old man with dysphagia, anorexia, and night sweats. Chest 138. (5): 1266-1270.2010; Citation

