

appreciated from the comments accompanying table 2 in our paper, our aim was to give an overview of the available options without being unduly prescriptive. In the paper we strongly promote close collaboration between general, respiratory, HIV, and intensive care physicians in order to deliver optimal care.

R J Boyton, D M Mitchell, O M Kon

Chest and Allergy Department, St Mary's Hospital
NHS Trust, London W2 1NY, UK;
r.boyton@imperial.ac.uk

References

- 1 **Boyton RJ**, Mitchell DM, Kon OM. The pulmonary physician in critical care. Illustrative case 5: HIV associated pneumonia. *Thorax* 2003;**58**:721–5.
- 2 **Stringer JR**, Cushion MT, Wakefield AE. New nomenclature for the genus *Pneumocystis*. Proceedings of the Seventh International Workshops on Opportunistic Protists. *J Eukaryot Microbiol* 2001;**48**(Suppl):184–9S.
- 3 **Stringer JR**, Beard CB, Miller RF, et al. A new name (*Pneumocystis jirovecii*) for *Pneumocystis* from humans. *Emerg Infect Dis* 2002;**8**:891–6.
- 4 **Smeego RA**, Nagar S, Maloba B, et al. A meta-analysis of salvage therapy for *Pneumocystis carinii* pneumonia. *Arch Intern Med* 2001;**161**:1529–33.

Adenocarcinoma of lung presenting with dysgeusia

A 69 year old woman, a smoker for 40 years, presented with an altered taste sensation. Investigations revealed hyponatraemia with a serum sodium level of 122 mmol/l. Serum osmolality ranged between 248 and 255 mosm/kg; corresponding urine osmolality was between 430 and 835 mosm/kg. Biochemical tests of thyroid, adrenal, renal and pituitary functions were normal. Computed tomographic (CT) and magnetic resonance imaging (MRI) scans of the brain and pituitary gland were normal. Her serum sodium level returned to normal with fluid restriction. A chest radiograph showed a

3 cm spiculated opacity in the retrocardiac region. A CT scan confirmed a mass in the lower lobe of the left lung which proved to be a moderately differentiated adenocarcinoma. It revealed significant mediastinal lymphadenopathy. Mediastinoscopy failed to identify any nodal involvement. A left lower lobectomy was performed with lymph node sampling. Immediately before surgery the serum sodium level was 137 mmol/l.

Her initial recovery from surgery was uneventful. However, the serum sodium levels started to fall from the fourth post-operative day and reached 117 mmol/l. She again complained of dysgeusia. Fluid restriction was commenced and her serum sodium levels recovered to 133 mmol/l with concurrent symptomatic improvement. Histopathological examination revealed a moderately differentiated adenocarcinoma, stage T2 N2 MX. At 6 weeks follow up her progress was satisfactory without any evidence of recurrence or metastasis. Her sodium values were now normal and she was symptom free.

Dysgeusia is a known manifestation of hyponatraemia.¹ The association between hyponatraemia due to the syndrome of inappropriate antidiuretic hormone (SIADH) and small cell lung cancer is well known.^{2,3} There are strict criteria for diagnosis of SIADH,³ all of which were fulfilled in this patient. In small cell lung cancer serum sodium levels return to normal within 1–3 weeks of initiating chemotherapy in about 80% of patients.³ In our patient the levels returned to normal 2 weeks after surgery. Endocrine paraneoplastic syndromes are well documented with small cell lung cancer but are less common with other forms of lung cancers.⁴ This is an interesting and unusual presentation of adenocarcinoma of the lung with dysgeusia as the sole symptom.

S Karthik, R Roop, N K Mediratta
Department of Cardiothoracic Surgery,
Cardiothoracic Centre, Thomas Drive,
Liverpool L14 3PE, UK

Correspondence to: Mr S Karthik, Specialist Registrar,
Department of Cardiothoracic Surgery, Yorkshire
Heart Centre, The General Infirmary at Leeds, Leeds
LS1 3EX, UK; suchkats@yahoo.com

References

- 1 **Markley EJ**, Mattes-Kulig DA, Henkin RI. A classification of dysgeusia. *J Am Diet Assoc* 1983;**83**:578–80.
- 2 **Kamoi K**, Ebe T, Hasegawa A, et al. Hyponatremia in small cell lung cancer. Mechanisms not involving inappropriate ADH secretion. *Cancer* 1987;**60**:1089–93.
- 3 **List AF**, Hainsworth JD, Davis BW, et al. The syndrome of inappropriate antidiuretic hormone (SIADH) in small-cell lung cancer. *J Clin Oncol* 1986;**4**:1191–8.
- 4 **De La Monte SM**, Hutchins GM, Moore GW. Paraneoplastic syndromes and constitutional symptoms in prediction of metastatic behavior of small cell carcinoma of lung. *Am J Med* 1984;**77**:851–7.

NOTICE

The Dr H M (Bill) Foreman Memorial Fund

The trustees of the above fund invite applications for grants relating to study in respiratory disease and allied fields (e.g. microbiology, histopathology, radiology, biochemistry, and molecular biology). Limited funds are available for registered medical practitioners to assist in travelling to countries other than their own to study respiratory disease and also for support for clinical research abroad. Intending applicants should write for further details to: Dr Brian H Davies, Llandough Hospital, Penarth, Vale of Glamorgan CF64 2XX, UK.