Importantly, K. Challen and co-workers fail to mention that PMEWS is a graded score for each parameter, rather than the categorical scores used in CURB, making PMEWS inherently more complex to use, especially outside the hospital. In addition, CRB-65 can be calculated without any laboratory or oximetric results.

The medical early warning score has the potential advantages of not being disease specific, and familiarity of use in some UK hospitals at least, for the assessment of patients already admitted to hospital. However, we know of no studies reporting its use as a tool for the hospital admission decision.

More detailed and prospective assessment will be required before pandemic medical early warning scores can be recommended in preference to a score validated in a number of populations and now adopted in a number of international community-acquired pneumonia guidelines (www.brit-thoracic.org/guidelines) [2–4].

S. Ewig* and M.A. Woodhead#
*Thoraxzentrum Ruhrgebiet, Klinik für Pneumologie und Infektiologie, Augusta-Kranken-Anstalt, Bochum, Germany. #Dept of Respiratory Medicine, Manchester Royal Infirmary, Manchester, UK.

REFERENCES

1 Lim WS, van der Eerden MM, Laing R, *et al*. Defining community acquired pneumonia severity on presentation to hospital: an international derivation and validation study. *Thorax* 2003; 58: 377–382.
2 Woodhead M, Blasi F, Ewig S, *et al*. Guidelines for the management of adult lower respiratory tract infections. *Eur Respir J* 2005; 26: 1138–1180.
3 Hedlund J, Stralin K, Ortqvist A, Holmberg H. Swedish guidelines for the management of community-acquired pneumonia in immunocompetent adults. *Scand J Infect Dis* 2005; 37: 791–805.
4 Schouten JA, Prins JM, Bonten M, *et al*. [Optimizing the antibiotics policy in The Netherlands. VIII. Revised SWAB guidelines for antimicrobial therapy in adults with community-acquired pneumonia]. *Ned Tijdschr Geneeskd* 2005; 149: 2495–2500.

DOI: 10.1183/09031936.06.00047806

Video-assisted thoracic surgery and extramedullary haematopoiesis

To the Editors:

We read with interest the article by KÜGLER *et al*. [1] on paravertebral intrathoracic extramedullary haematopoiesis (EMH). Intrathoracic EMH was first noted by Guizetti as early as 1912 during an autopsy, and is typically located in the lower retropleural paravertebral region [2]. In addition to the congenital haemolytic anaemias, myeloproliferative syndromes and bone marrow insufficiencies described, EMH can also occur as a reactive process to chronic anaemic conditions, such as pernicious anaemia, B_{12} folate deficiency and Gaucher's disease.

The diagnosis of intrathoracic EMH can be difficult, and clinicians should have a high index of suspicion if the patient has a history of chronic anaemia. Neurogenic tumours (particularly neurolemmoma) remain the most common cause of a posterior mediastinal mass [3]. Other possibilities include hydatid cysts, liposarcoma, lateral meningocele, cartilaginous tumours, lymphoma and azygous lobes. On computed tomography scanning, intrathoracic EMH is well circumscribed and has smooth borders, it is homogeneous in character, generally noncalcified and may have adipose tissue within the mass. Magnetic resonance imaging may be useful in some cases to demonstrate adipose components in the mass and adjacent bone cortex integrity [3]. When the target site is situated away from the reticulo-endothelial organs, radioactive ^{99M}Tc sulphur colloid or iron-52 marrow scans can be used to demonstrate areas of haematopoietic activity, and thereby

FIGURE 1. Intra-operative photo of a video-assisted thoracic surgery biopsy of intrathoracic paravertebral extramedullary haematopoeisis.

''light up'' the EMH regions [4]. Nevertheless, we agree that a definitive diagnosis can only come from biopsy of the mass.

In our experience, fine-needle aspiration often provides insufficient material for confirmatory cytological examination and may even be misleading [2, 5]. A percutaneous biopsy approach can be technically difficult due to the specific location of the mass. Also, there is a significant risk of severe bleeding if the lesion is highly vascular [2]. Recently, we have advocated video-assisted thoracic surgery biopsy with intraoperative frozen section for the diagnosis of this condition (fig. 1). Video-assisted thoracic surgery carries the advantages of an open biopsy by direct visualisation of the mass. In addition, any haemorrhage that results from the biopsy can be better controlled compared with the percutaneous approach. Furthermore, the lesion can be resected in the same operation with minimal trauma.

C.S.H. Ng, S. Wan, M.J. Underwood and A.P.C. Yim
The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, Hong Kong.

REFERENCES

1 Kügler D, Jäger D, Barth J. A patient with pancreatitis, anaemia and an intrathoracic tumour. *Eur Respir J* 2006; 27: 856–859.
2 Catinella FP, Boyd AD, Spencer FC. Intrathoracic extramedullary hematopoesis simulating anterior mediastinal tumour. *J Thorac Cardiovasc Surg* 1985; 89: 580–584.
3 Lukanich JM, Bueno R, Sugarbaker DJ. Posterior mediastinal masses. *In*: Yim APC, Hazelrigg SR, Izzat MB, Landreneau RJ, Mack MJ, Naunheim KS, eds. Minimal Access Cardiothoracic Surgery. Philadelphia, WB Saunders, 1999; pp. 221–231.
4 Bronn LJ, Paquelet JR, Tetalman MR. Intrathoracic extramedullary hematopoiesis: appearance on ^{99m}Tc sulfur colloid marrow scan. *AJR Am J Roentgenol* 1980; 134: 1254–12555.
5 Loh CK, Alcorta C, McElhinney AJ. Extramedullary hematopoiesis simulating posterior mediastinal tumours. *Ann Thorac Surg* 1996; 61: 1003–1005.

DOI: 10.1183/09031936.06.00045406