early, yielding mediastinal lymph node metastases or distant metastases (generally in the liver or in the brain) at the time of diagnosis.

Correct preoperative diagnosis of neuroendocrine carcinoma of the lung (and also of LCNC) is really difficult to obtain either by bronchoscopy or by transthoracic biopsy; in the case of clinical N2 neuroendocrine carcinoma, a surgical approach can be considered, because these tumors do not respond to neoadjuvant therapy.⁴ This could be appropriate in case of bronchial carcinoid, but not in case of LCNC. For these tumors, I believe, neoadjuvant treatment is mandatory because of their aggressive biologic behavior.

In this study Takei and colleagues¹ pointed out the importance of the immunohistochemical assessment, with the detection of chromogranin A staining in neoplastic cells. We must remember that LCNCs, because they are neuroendocrine carcinomas, express somatostatin receptors, which can be easily detected in vitro by reverse transcriptase polymerase chain reaction.⁵ In vivo expression of these receptors is provided by indium 111-tagged diethylenetriaminepentaacetic acid pentetreotide (OctreoScan, OCT) scintigraphy.^{6,7} This procedure is widely accepted both in the preoperative evaluation of neuroendocrine carcinoma, because of its effectiveness in detecting mediastinal or distant metastases with high sensitivity, and in follow-up for early detection of tumor recurrences or distant metastases.⁸ In case of positive OCT scintigraphy result, therapy with octreotide (new generation somatostatin analog) might be considered, alone or in association with chemotherapy. I believe that such an important biologic concept might be considered in the correct multidisciplinary treatment of LCNC of the lung. Octreotide has been proved to be effective in controlling metastatic growth, well tolerated by the patient, and without important side effects.^{8,9}

In conclusion, I congratulate Takei and colleagues¹ for this excellent article on such a difficult matter. I recommend the use of OCT scintigraphy in the preoperative evaluation of these patients and in their follow-up. Furthermore the use of octreotide (in the case of positive results of OCT scintigraphy), in association with traditional adjuvant therapy, might be consid-

ered to reduce the risk of tumor recurrence or distant metastases.

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Reply to the Editor:

We appreciate the thoughtful comments by Filosso on our recent article¹ describing the clinicopathologic aspects of large cell neuroendocrine carcinoma (LCNC) of the lung.

The histologic type of LCNC of the lung has been included as the subtype of large cell carcinoma in the revised World Health Organization classification of lung and pleural tumors in 1999.² The clinico-

pathologic features, however, have not been described in detail. Especially little is known about the response of LCNC to the chemotherapy and radiotherapy. Considering the analogy of LCNC to the small cell histologic type, a multimodal therapeutic approach might be expected to be promising.

As Filosso pointed out, we also have a great interest in the expression of somatostatin receptors in LCNC. If these receptors are expressed frequently in LCNC, octreotide scintigraphy with somatostatin analog (OctreoScan) would reasonably be of great utility in the preoperative evaluation of extent of disease of LCNC. Indeed, carcinoid tumor and small cell carcinoma have already been shown to be well analyzed by octreotide scintigraphy.^{3,4} As for LCNC, however, according to a report by Jiang and colleagues,⁵ only 9 (40.9%) of 22 cases were shown to stain positively for somatostatin, and these tumor cells do not necessarily express somatostatin receptors. Whether octreotide scintigraphy can be used depends on the rate of expression of somatostatin receptors. At present no data are available on the expression of somatostatin receptors in LCNC.

Furthermore, the preoperative establishment of a histologic diagnosis of LCNC is crucial in planning the LCNC-specific treatment strategy. However, it is actually quite difficult to get the histologic or cytologic diagnosis of LCNC simply by the evaluation of tiny preoperative biopsy specimen. Novel LCNC-specific markers ("immunohistochemically detectable") must be sought; such markers would easily enable the histologic diagnosis of LCNC.

Again, we pointed out that LCNC should be recognized as one of the poorest prognostic subgroups in lung cancer, and novel therapeutic approaches should be established. Further accumulation of clinicopathologic characteristics, especially the response to nonsurgical treatment, is the most important issue. The histologic classification of lung tumors with neuroendocrine phenotype also seems to need further revision in the near future.

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Tuberculous aneurysms of the aorta To the Editor:

We read with interest the brief report on tubercular aneurysm of the descending thoracic aorta published in February 2002 issue of the *Journal*.¹ The reported case highlights the rare nature of the condition and the catastrophic presentation in a pa-

tient receiving antitubercular drugs for disseminated tuberculosis.

We recently published our group's experience with 5 cases of tuberculous pseudoaneurysms of the aorta successfully treated at our unit during a 3-year period between 1997 and 1999.² The sites of involvement in these 5 patients included the ascending aorta, distal aortic arch, proximal descending thoracic aorta, distal descending thoracic aorta, and infrarenal abdominal aorta, thus indicating that any segment of the aorta may be involved in an appropriate clinical setting. All these patients had received antitubercular drugs in the past and were first seen with sudden deterioration in clinical status. Because tuberculosis is not uncommon in our part of the world, we promptly suspected the diagnosis, leading to successful management. Since then we have successfully managed 3 more cases of pseudoaneurysm of the aorta. Two of these lesions occurred in the infrarenal aorta, and 1 occurred in the descending thoracic aorta. Thus in the past 5 years we have come across 8 patients with this condition. This diagnosis is therefore not that uncommon if the diagnosis is suspected in the appropriate clinical setting.

A striking feature in all these cases was that the aneurysm was saccular in nature. This is probably because most of these lesions are pseudoaneurysms. This is important, because pseudoaneurysm of

the aorta in a patient with active or treated tuberculosis may point to the diagnosis.

Before our report, only 88 cases of this condition had been reported in the English-language medical literature.² We believe that as the incidences of drug-resistant and human immunodeficiency virus-associated infection rise, the entity will be encountered more frequently.

Because the condition may present with catastrophic symptoms and signs, ready anticipation of the diagnosis is required to achieve an optimal outcome. Histopathologic examination and culture of the tissue from the aneurysm wall should be a routine. This may help to identify and institute the correct drug treatment in such cases.

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