

Retroperitoneal Sarcoma

TO THE EDITOR: In our opinion, the mass described as a myxoid liposarcoma and shown in the January 29 Images in Clinical Medicine¹ is not an example of that entity but, rather, an atypical lipomatous tumor (well-differentiated liposarcoma) with secondary myxoid features. These two tumor types differ considerably on topographic, gross, microscopic, molecular genetic, and prognostic grounds, and their distinction is therefore of importance.

Juan Rosai, M.D.
Silvana Pilotti, M.D.

Istituto Nazionale Tumori
20133 Milan, Italy

1. Napolitano LM. Retroperitoneal sarcoma. *N Engl J Med* 2004; 350:493.

THE AUTHOR AND COLLEAGUES REPLY: We agree with Drs. Rosai and Pilotti that the clinical behavior of liposarcoma closely reflects its histologic type, so that the identification of the histologic subtype is very important for both prognosis and therapy. In this case, pathological examination of tissue from the initial resection provided the grounds for the diagnosis of myxoid liposarcoma, which was confirmed by the Armed Forces Institute of Pathology.

The pathological findings on examination of the recurrent retroperitoneal sarcoma also confirmed the diagnosis of myxoid liposarcoma. In addition to myxoid areas, the specimen had areas with morphologic features of low-grade (well-differentiated) liposarcoma, but the overall morphologic findings were most consistent with the general category of myxoid liposarcoma. We did not confirm this diagnosis by cytogenetic analysis.

Rosai and Pilotti's opinion was based on the small photograph of a histologic section that was provided with the case report, which may not have been fully representative of myxoid liposarcoma. However, our pathology department staff had the opportunity to review multiple areas of the very large tumor at the initial surgery and in the recurrent tumor.

Lena M. Napolitano, M.D.
Dong H. Lee, M.D.

Baltimore Veterans Affairs Medical Center
Baltimore, MD 21201

Andrew Borkowski, M.D.

Tampa Veterans Affairs Medical Center
Tampa, FL 33612

Case 9-2004: An 18-Year-Old Man with Respiratory Symptoms and Shock

TO THE EDITOR: In the case of influenza presented by Todres and discussed by Gerberding et al. (March 18 issue),¹ there are two points that need further examination. First, the obese patient had received at least 20 liters of fluid in 32 hours before he died from unremitting shock, yet no mention is made of measurement of the intraabdominal pressure. There is a growing body of evidence that suggests that the body-mass index and massive fluid resuscitation are the main independent causes of intraabdominal hypertension.^{2,3}

Second, the patient received hydrocortisone after he was found to have a baseline cortisol level of 27.1 µg per deciliter (748 nmol per liter) that increased to 41.5 µg per deciliter (1145 nmol per liter) after the administration of cosyntropin. According to a study by Annane et al.,⁴ this patient would

be classified in the lowest risk group — patients who are considered to have “adequate” activation of the hypothalamic–pituitary–adrenal axis and who would probably not benefit from the administration of corticosteroids.

Petros Kopterides, M.D.

Attikon University Hospital
12462 Athens, Greece
petkop@ath.forthnet.gr

1. Case Records of the Massachusetts General Hospital (Case 9-2004). *N Engl J Med* 2004;350:1236-47.
2. Malbrain ML. Abdominal pressure in the critically ill: measurement and clinical relevance. *Intensive Care Med* 1999;25:1453-8.
3. *Idem*. Is it wise not to think about intraabdominal hypertension in the ICU? *Curr Opin Crit Care* 2004;10:132-45.
4. Annane D, Sebille V, Troche G, Raphael JC, Gajdos P, Bellissant E. A 3-level prognostic classification in septic shock based on cortisol levels and cortisol response to corticotropin. *JAMA* 2000;283:1038-45.

THE DISCUSSANT REPLIES: Measurement of the intra-abdominal pressure was not performed in this patient. However, it is unlikely that a clinically significant increase in abdominal pressure was present because mechanical ventilation was effectively carried out with relatively low peak inspiratory pressures and positive end-expiratory pressures. With regard to the administration of hydrocortisone, testing for the cortisol response was performed be-

fore the administration of the drug, which was then continued until the test showed a positive result, thus no longer indicating that the drug was needed in this patient.

I. David Todres, M.D.

MassGeneral Hospital for Children
Boston, MA 02114

Correspondence Copyright © 2004 Massachusetts Medical Society.

INSTRUCTIONS FOR LETTERS TO THE EDITOR

Letters to the Editor are considered for publication, subject to editing and abridgment, provided they do not contain material that has been submitted or published elsewhere. Please note the following: •Letters in reference to a *Journal* article must not exceed 175 words (excluding references), must be received within three weeks after publication of the article, and must be submitted over the Internet at <http://authors.nejm.org>. Letters not related to a *Journal* article must not exceed 400 words and may be submitted over the Internet or sent, typewritten and triple-spaced, by mail. •A letter can have no more than five references and one figure or table. •A letter can be signed by no more than three authors. •Financial associations or other possible conflicts of interest must be disclosed. (Such disclosures will be published with the letters. For authors of *Journal* articles who are responding to letters, this information appears in the original articles.) •Include your full mailing address, telephone number, fax number, and e-mail address with your letter.

Our address: **Letters to the Editor • *New England Journal of Medicine* • 10 Shattuck St. • Boston, MA 02115**

Our Web address: **<http://authors.nejm.org>**

Our fax numbers: **617-739-9864 and 617-734-4457**

We cannot acknowledge receipt of your letter, but we will notify you when we have made a decision about publication. Letters that do not adhere to these instructions will not be considered. Rejected letters and figures will not be returned. We are unable to provide prepublication proofs. Submission of a letter constitutes permission for the Massachusetts Medical Society, its licensees, and its assignees to use it in the *Journal's* various print and electronic publications and in collections, revisions, and any other form or medium.