capsulatum. We anticipate investigating the specificity of spherulin further in a large population sample residing in an exclusively H. capsulatum-endemic area. Also, clinical studies are in progress to determine the efficacy of this reagent in patients with active coccidioidomycosis. In chronic pulmonary cavitary disease, acute pulmonary disease, and disseminated disease, the response to coccidioidin is frequently nonreactive.

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REFERENCES

Superior Vena Caval Obstruction

There are wide variations in the symptomatic manifestations and diagnostic findings in superior vena caval obstruction because the latter may be partial or complete; it may take place gradually, insidiously or with dramatic, alarming suddenness. Also, the competency of blood flow through collateral channels (azygous, lateral thoracic, internal mammary, vertebral and portal veins) may vary to a great extent. Absence of pertinent symptoms does not rule out this condition. Failure, H J et al (Proc Staff Meet Mayo Clin 33:671, 1958) found on autopsy that 12 percent of individuals with superior vena caval obstruction had entirely negative past history relative to it. Slowly developing complete occlusion may be compatible with life. Commonly, these patients seek medical attention because of some of the following symptoms: headache, pressure in the head, lightheadedness, dizziness, dizzy spells, tinnitus, blurring of vision, nausea, dyspnea, choking sensation, hemoptysis, nose bleed, cough, somnolence, convulsions, syncopal attacks. Some of these symptoms may decrease in the standing position and likely to be aggravated in recumbency, on bending over, exertion, straining, and coughing. On inspection, one may note flushing or dusky discoloration of the face and neck or cyanosis, also, puffiness of the eyelids, periorbital edema, proptosis, suffusion of the conjunctiva, edematous swelling of the face, neck, supraclavicular area and of the upper extremities; too, one may find telangiectasia over the chest wall, upper abdominal wall and upper part of the back, together with distention of the jugular veins and veins of the arms, chest wall and esophagus. Objective findings are: high central venous pressure, elevated antecubital venous pressure up to 300 to 500 mm of isotonic saline solution. The antecubital venous pressure increases on inspiration, a change opposite to that found in healthy persons; it rises on exercise in contrast to findings in heart failure. Cerebrospinal fluid pressure is high. X-ray likely to reveal widening of the upper mediastinum or obliteration of the retrosternal space. Other possible changes include mediastinal and/or pulmonary masses, enlarged lymph nodes, large hemiazygos vein, rib notching, and in some cases pleural effusion. Venous angiography is an essential means of diagnosis. Radioisotope scintigraphy with 99mTc (sodium pertechnetate) has been found useful in pertinent diagnostic studies by several investigators. Since the time of the first recorded instance of superior vena caval obstruction by Hunter, W (Med Obs Inquir, London, 1:323, 1757), a great many reports have dealt with the etiology of this condition. The following factors are of particular interest: carcinoma of the lung, mediastinal neoplasms, benign or malignant, fibrous mediastinitis (idiopathic or due to syphilis, tuberculosis, rheumatic fever, radiation therapy, perforation of lung abscess or of the esophagus. Also, one should consider the possibility of mediastinal hematoma, constrictive pericarditis, mediastinal cyst, sarcoidosis, and thrombosis of the superior vena cava. Mazzei, E A et al (Ann Thorac Surg 11:243, 1971) observed a case of superior vena caval syndrome following complete correction (Mustard repair) of transposition of the great vessels, due to delayed stricture of the intraatrial pericardial baffle used in the operation. Reoperation was followed by complete recovery.

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