tion should he develop an infiltrate in the irradiated area. Its occurrence is not limited to patients who have completed their course of radiation therapy. Correct diagnosis of this entity is essential because of its occasional severe morbidity, excellent response to corticosteroid therapy, and potential hazards of inappropriate antibiotic therapy.

References

Ill-Effects of Cardiac Resuscitation: Report of Two Unusual Cases*

Steven G. Aitcheson, M.D.,** Gary V. Petersen, M.D.,† and Herbert L. Fred, M.D., F.C.C.P.*

Two mishaps associated with closed-chest cardiac resuscitation are presented. One—pneumoperitoneum—became evident during life, created considerable diagnostic difficulty, and evoked treatment that possibly hastened the patient’s death. The other—cardiac puncture—appeared at autopsy and its mechanism may be unique.

We recently witnessed two bizarre complications of cardiac resuscitation. The therapeutic and philosophic implications of these accidents are important and form the basis of this communication.

Case Reports

Case 1

At entry into the hospital, this 82-year-old woman had physical and chest roentgenographic signs of congestive heart failure. Therapy with digitalis and diuretics resulted in substantial clinical improvement. One week after admission she suddenly manifested ventricular fibrillation. External cardiac massage, electric countershock, and ventilation via face mask restored sinus rhythm and normal blood pressure in ten minutes. Midway through the procedure, progressive abdominal distension occurred. Chest roentgenogram revealed free air beneath each hemidiaphragm, but none in the mediastinum, pericardium, pleura, or subcutaneous tissues. During the next several hours, abdominal distension persisted and her rectal temperature rose to 38.9° C. Gastric perforation seemed likely, and we reluctantly proceeded with celiotomy. Operation demonstrated massive, unexplained pneumoperitoneum. Her condition then steadily worsened, and she died four days later.

Autopsy established no cause of her pneumoperitoneum. She did have bronchopneumonia in both lower lobes, severe coronary atherosclerosis, and recent subendocardial infarction. Notably absent was evidence for lacerated intestine, peritonitis, fractured ribs, or intrathoracic injury.

Comment: This case emphasizes that pneumoperitoneum consequent to closed-chest cardiac resuscitation need not reflect perforated gut. At least five patients have displayed postresuscitative pneumoperitoneum. In two, our patient and another,† the site and nature of air leak defied detection. Two others,‡ had ruptured stomach, and the fifth¶ had ruptured esophagus just proximal to the stomach.

A second point commands attention. Prompt surgical intervention in all of the aforementioned patients benefited just two.¶ Hence, when pneumoperitoneum complicates resuscitation, a trial of judicial medical management may be wise.

Case 2

Several hours after sustaining an acute inferior myocardial infarction, a 78-year-old man suffered cardiac standstill. Resuscitative efforts failed. Postmortem examination disclosed extensive coronary atherosclerosis and a number of exceptional abnormalities. Several sharply pointed vertebral osteophytes measuring 2 x 2 x 1 cm and resembling railroad spikes lay directly behind and impinged upon the heart. Liquid and clotted blood filled the pericardium. A half-centimeter hole extended through the pericardium and posterior wall of the left ventricle. Muscle surrounding the hole looked normal; on cut sections, however, the fibers were fragmented and incompletely striated, findings suggesting early infarction. Although the mechanism of perforation remains uncertain, we believe that during chest-wall compression an osteophyte “back-stabbed” the patient, piercing his heart.

Comment: This case brings into focus a fact and two questions. The fact is: Complications of successful closed-chest cardiac resuscitation kill some patients.¶ The questions are: 1) What kills the patient such as ours, and cardiac arrest or cardiac massage? and 2) Can one prevent catastrophes of resuscitation? Answers are conjectural at best.

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REFERENCES


A Cutaneous Manifestation of Untreated Disseminated Histoplasmosis*

Thomas M. O’Dorisio, M.D., ** David A. Jasper, M.D.,† and James Sullivan, M.D.‡

We present a case of histoplasmosis with skin manifestations occurring 17 years after initial diagnosis. The clinical manifestations of disseminated histoplasmosis are discussed. Amphotericin B administered through an A-V shunt resulted in prompt resolution of the skin lesions.

Untreated progressive disseminated histoplasmosis is usually fatal.1 Sarosi et al2 reported that 50 percent of their patients with disseminated histoplasmosis died within four months after diagnosis.

Although the manifestations of progressive disseminated histoplasmosis are protean, cutaneous involvement is rare.3 In a recent study of 25 adult patients with progressive disseminated histoplasmosis,4 only one patient presented with multiple subcutaneous abscesses from which Histoplasma capsulatum was cultured.

We report a case of untreated progressive disseminated histoplasmosis. Seventeen years after the initial diagnosis, this patient developed secondary periorbital...