of the pleural fluid and stains of sections of tissue from the pleural biopsy were negative for acid-fast bacilli and fungi. A presumptive diagnosis of tuberculous pleuritis was made, and the patient was discharged on a regimen of isoniazid and ethambutol.

Three weeks later, cultures of both sputum and pleural fluid were reported to be positive for Blastomyces dermatitidis. The patient had lost 0.9 kg (4 lb), and her left pleural effusion was still present. The fungal complement-fixation test for Blastomyces was positive at a titer of 1:64. The patient was treated with 1,425 mg of amphotericin B, and after five months, her chest x-ray film was normal. Her intermediate-strength PPD skin test remained negative.

**DISCUSSION**

A patient with an exudative pleural effusion and evidence of granulomatous disease on pleural biopsy is generally presumed to have tuberculous pleuritis. In two large series,1,2 granulomatous pleuritis was found in 213 specimens from pleural biopsies, and even though proof by culture was lacking in 109 of the patients, all were considered to have tuberculous pleuritis. Like the patients in these series, our patient was originally thought to have tuberculous pleuritis.

It is known that fungal disease of the pleura can produce granulomatous pleuritis. Schub and associates3 reported three cases of granulomatous pleuritis secondary to histoplasmosis, and Brewer and Himmelwright4 reported one additional case. Sokolowski et al5 reported a case of granulomatous pleuritis secondary to cryptococcosis. The granulomatous pleuritis in each of the previous instances was found at open thoracotomy.

Pleural involvement is believed to be uncommon with blastomycosis. In the Veterans Administration cooperative study6 of 198 patients with blastomycosis, only four patients had pleural effusion, and in only one was the culture of pleural fluid positive for blastomycosis; however, a recent report of 50 cases from our hospital showed pleural changes in 13 (26 percent).7

It should be stated that granulomatous pleuritis may at times occur with noninfectious diseases. A small percentage of patients with sarcoidosis8 or with rheumatoid pleuritis9 will have an exudative pleural effusion with granulomas on aspiration biopsy of the pleura.

Although the great majority of patients with granulomatous pleuritis will have tuberculosis, a small percentage will have fungal disease. Therefore, fungal smears and cultures of the sputum and pleural fluid should be obtained from all such patients.

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**The Professional Cardioversion Patient**

A New Medical and Psychiatric Entity

To the Editor:

Conversion of cardiac arrhythmias by electrical countershock is a well-established medical treatment1 which may generate higher-than-justified hopes for patients whose cardiac problems are interwoven with strong emotional factors. Such patients need not only immediate medical care, but also psychiatric consultation geared toward crisis intervention. The following abstract of a clinical case describes such a patient:

**CASE REPORT**

On Nov 7, 1974, a 54-year-old white man came to the emergency room of a large, voluntary, not-for-profit hospital for treatment of shortness of breath and severe chest pains of a few hours' duration. The past history included bronchial asthma for the last three years and a cardiac arrhythmia for the last 18 months, for which the patient had undergone several unsuccessful cardioversions. He was rather vague as to specific details of where these procedures took place.

On further questioning, the patient stated that he had been a patient at two leading hospitals in New York City for similar problems. His history of medications included quinidine, aminophylline, and choline theophyllinate (Cholcedyl).

The physical examination revealed an obese white man in no acute distress, who seemed to be very much up-to-date in medical terminology. Expiratory wheezes were audible. The pulse rate was 90 beats per minute and irregular. The patient had two fresh marks on his chest that look like marks from cardioversion, but he refused to admit that he...
had undergone cardioversion recently. The patient was admitted to the coronary care unit and monitored. Electrocardiographic study revealed atrial flutter and fibrillation with variable atrioventricular block. The atrial rate was 280 impulses per minute, and the ventricular rate varied between 90 and 120 impulses per minute.

The patient remained in the coronary care unit for approximately ten hours and was monitored continuously. The vital signs remained stable, and his arrhythmia did not change, except for a slower ventricular response. Rhythm strips also revealed aberrant conducted beats. A chest x-ray film showed no apparent active parenchymal lesion; the left ventricle appeared hypertrophic. The most impressive fact about this patient was that he continuously and repeatedly demanded and requested cardioversion as a method of treatment, claiming that this was the only thing that could help him. Repeated explanations on the part of the medical and nursing staff were of no avail, and when the patient finally convinced himself that cardioversion would not be available to him on demand, he signed himself out against medical advice and left the medical center, in good condition.

Additional inquiries into this patient's history revealed that he also had come to an affiliated hospital nine days earlier, with similar complaints, and demanded to undergo cardioversion. Furthermore, on Nov 17, 1974, nine days after he signed himself out of our medical center, the patient again came to the emergency room complaining of chest pain and palpitations and gave a history of rheumatic fever since the age of 12 years. The physical examination in the emergency room at that time revealed a well-built man in no distress, with an irregular pulse rate of 122 beats per minute, blood pressure of 140/100 mm Hg, and vesicular breath sounds. The patient demanded to undergo cardioversion by the medical staff as the only method of treatment. Electrocardiographic studies revealed atrial flutter with varying atrioventricular conduction, unchanged from the previous record. The patient signed out of the emergency room when he realized that the medical staff would not offer cardioversion on demand.

Three months later, I engaged in a follow-up telephone conversation with a relative of the patient, probably his wife, who was unwilling to identify herself as such. She recalled that during 1½ months in 1974, the patient had undergone at least seven cardioversions at various New York City metropolitan hospitals, which maintained his rhythm as regular for no more than one or two days, after which he invariably reverted back to his irregular rhythm. This lady did not know exactly how many cardioversions the patient had had in the last 18 months, but she did know, as a fact, that he went from hospital to hospital in the metropolitan area demanding and, many times, receiving cardioversions. I advised the patient through this intermediary to stop running from hospital to hospital for his own good, and she promised me that she would transmit the message.

Additional telephone verification was obtained through a telephone inquiry to eight large teaching hospitals in metropolitan New York City where the patient was hospitalized between January and November 1974. The length of the hospitalization was, in each and every case, one day or less and was terminated by the patient leaving the hospitals against medical advice.

**DISCUSSION**

The profile of such a professional cardioversion patient includes the following characteristics: an ability to describe symptoms and signs, and versatility with medical nomenclature; a white-collar occupation; a history of numerous short-term hospitalizations (one day or less in many hospitals); documented contradictions in the patient's history; suspicious marks of recent cardioversion on the anterior surface of the chest; and nervousness and anxiety. The main characteristic, however, is the persistent demand for cardioversion as the single method of treatment.

In summary, medical and nursing staff should be suspicious whenever a patient requests or demands cardioversion as the sole method of treatment. Further inquiry should be made regarding the veracity of alleged symptoms and signs, and careful scrutiny of the patient's history of treatments should be undertaken. Telephone contacts requesting additional information must be initiated with other hospitals, emergency rooms, and physicians, as well as with members of the patient's family. The presence of cutaneous lesions resembling attempted or unsuccessful therapy via electrical countershock raises further doubt about the presenting syndrome. No hesitation should delay the need for a psychiatric consultation geared toward crisis intervention.

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**REFERENCE**


**Spontaneous Pneumothorax with Metastatic Malignant Melanoma**

To the Editor:

Recently, we observed a patient with widespread malignant melanoma in whom spontaneous pneumothorax developed. This has not been reported in the English literature.

**CASE REPORT**

A 46-year-old white man had undergone local excision of a 1.5-cm malignant melanoma of the scalp in August 1972. Twelve months later, it metastasized to the right submandibular lymph node; this was subsequently excised.

In June 1974, the patient was hospitalized because of anorexia and weakness. Prominent hepatosplenomegaly was noted on examination and scan; the latter showed multiple filling defects. Chest x-ray films revealed a 1.8-cm nodule in the left hilar area. Proctoscopy disclosed a metastatic melanoma located 14 cm above the anus. The patient received two courses of polychemotherapy with hydroxyurea, 1,3-bis-(2-chloroethyl)-1-nitrosourea, dimethylbisaenimidazo-carboxamide, and vincristine in July and August; however, hepatosplenomegaly increased. A chest x-ray film in late August showed moderate left pleural effusion.

Twelve days later, the patient suddenly developed sharp