It is surprising that the medical profession, which is so hasty in applying eponyms to even a single case report, has been so slow to tag tobacco addiction. After all, Dorothea Dix reported eight admissions to the Massachusetts State Hospital due to the abuse of snuff and tobacco as early as 1857. We can and should do better than that now.

We can start by making this diagnosis and recording it in every chart, hospital record, and death certificate where appropriate. A notice of this type should be in every medical journal and communication from medical organizations concerned about the injurious effects of tobacco. Significant series of statistics to document the extent of this serious problem should be published and added to the Surgeon General's already significant data. Finally, this information should be forcefully brought to the attention of the third party payment and insurance carriers. This new official nomenclature may not be dramatic for the psychiatrists, but for the rest of us, there is a lot in it that can be quite effective if we make the effort.

Theodore H. Noehren, M.D., F.C.C.P.
Salt Lake City, Utah

Reprint requests: Dr. Noehren, 1060 East First South, Salt Lake City 84102

Histoplasma capsulatum Endocarditis

Endocarditis is a rare, occasionally solitary, manifestation of disseminated histoplasmosis. In the 28 cases described, the age has ranged between 17 and 74 years, with a mean of 48 years. There has been a striking male preponderance (23 men, 5 women). All patients were inhabitants of the Ohio-Mississippi Valley region and the eastern United States. The presenting symptoms were the usual ones of subacute endocarditis: fever, chills, fatigue, malaise, anorexia, and embolic events.

Physical examination results were remarkable for fever in 96 percent of the patients, a murmur in 76 percent, hepatomegaly and splenomegaly were each present in 48 percent, petechiae in 35 percent, and major artery embolization in 32 percent. Anemia was present in 71 percent. Leukopenia, which is common in chronic disseminated histoplasmosis, was present in 50 percent, and only 5 percent of the patients had leukocytosis on presentation.

Aortic valve infection was most common (58 percent), and mitral (31 percent) and tricuspid (8 percent) valve involvement was less frequent. Two cases had infection of multiple valves. Underlying cardiac abnormalities were present in one-half of the cases. Rheumatic heart disease was the most common preexisting cardiac lesion, but individual cases of bicuspid aortic valves, atrial myxoma, and aortic valvulitis have been reported. There have been two cases of endocarditis of prosthetic aortic valves.

The difficulty in establishing an etiology was emphasized by the fact the average length of time to diagnosis was nine months, with a range of two to 37 months. Diagnosis has been established through biopsy specimens or cultures of liver, bone marrow, oropharyngeal ulcers, or urine. Only two patients had positive blood cultures. Cutaneous delayed hypersensitivity reaction to Histoplasma capsulatum antigen was of no diagnostic value. However, high titers of complement fixation serology (1:256 or greater) strongly suggested disseminated histoplasmosis and warranted therapy, in the appropriate clinical setting, without positive cultures. Vegetations, indistinguishable from those caused by bacteria, have been described by echocardiography.

The difficulty in establishing the etiology has resulted in a high mortality rate. The overall survival has been 21 percent; the disease was uniformly fatal before the introduction of amphotericin B. However, 60 percent of cases treated with amphotericin B have survived. Furthermore, five of six patients receiving 2 g or greater of amphotericin B have survived, while three of four patients who received less than 2 g (including one who received two courses of 1.5 and 1.2 g, respectively) failed to survive. Two patients with prosthetic valve endocarditis died without adequate therapy. The indications for valve replacement are the same as in other forms of endocarditis: congestive heart failure not responding to medical therapy, uncontrollable infection, or recurrent emboli.

Clinical suspension resulting in earlier diagnosis and adequate therapy with amphotericin B will result in substantial improvement in survival in a previously uniformly fatal disease.

Timothy Blair, LCDR(MC), USNR, and Lawrence Raymond, CDR(MC), USN
Bethesda

Department of Cardiology, National Naval Medical Center. The opinions and assertions herein are those of the authors and should not be construed as official or as reflecting the views of the U.S. Navy Department.

Reprint requests: LCDR Blair, Cardiology, National Naval Medical Center, Bethesda 20014

REFERENCES

CHEST, 79: 6, JUNE, 1981

620 EDITORIALS