Clinical History

This patient is a 39 year-old laborer from the San Joaquin Valley who presented with the symptoms of fever, malaise, arthralgia and headache. These symptoms had been present intermittently for two years and were slowly progressive. No respiratory symptoms had ever been noted. Past history revealed a childhood exposure to tuberculosis and a long history of drinking unpasteurized milk.

The chest film revealed a thin-walled cavity in the posterior segment of the left upper lobe without surrounding inflammatory disease. Repeated smears for tuberculosis, skin tests for coccidioidomycosis, histoplasmosis, and tuberculosis, and complement fixation tests for coccidioidomycosis and brucella were all negative.

Answer: COCCIDIOIDOMYCOSIS

While under observation, the cavity slowly enlarged, and a segmental resection was performed. Coccidioides immitis was recovered from the resected specimen.

Other pulmonary manifestations of coccidioidomycosis besides cavitation are hilar adenopathy, non-specific bronchopneumonia and the coin lesion, or coccidioma. Approximately 2 to 3 per cent of patients ill enough to seek medical attention have cavities. These may be anywhere in the lung and may develop at the site of a bronchopneumonia. They are
typically thin-walled without surrounding parenchymal inflammation, although a coccidioidal bronchopneumonia or secondary infection may coexist with the cavity, making differentiation from tuberculosis or lung abscess difficult. Indeed, several cases of coccidioidomycosis and tuberculosis in the same patient have been reported.

REFERENCES

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The Committee on Chest Roentgenology welcomes comments. We would also be pleased to receive x-ray films of exceptional interest with brief history. Please submit material to: Benjamin Felson, M.D., chairman, Department of Radiology, Cincinnati General Hospital, Cincinnati, Ohio.

PRESENT STATUS OF BRONCHOPLASTY
Recent literature on bronchoplasty was reviewed and indications, techniques and results of 285 cases were introduced. The results of this surgical procedure have been satisfactory. It should be performed more frequently for repair of chronic airway stenosis and treatment of cancer and trauma.

Suturing, anastomosing and partial transplantation methods have yielded good results. End-to-end anastomosis of the bronchus is the best for repairing the resected bronchus, but the length of the resection is naturally limited in this way. The upper limit of the length of resection which can be anastomosed has been found by the author.

On the main bronchus, 4 cm. length of resection is anastomosable when upper lobectomy is combined.


FIBROELASTOSIS OF THE HEART: CLINICAL AND HEMODYNAMIC FEATURES OF 18 CASES
In fibroelastosis of the heart, the symptoms of frequent respiratory infections, failure to grow, pallor and dyspnea are nonspecific. However, when these are associated with a gallop rhythm and with signs of cardiac enlargement or failure, the condition may reasonably be suspected. Supporting radiologic evidence of left atrial enlargement and normal lung vascularity and P-wave perversions on the electrocardiogram make the diagnosis much more likely.

In the older child, the differential diagnosis from the effects of rheumatic fever may be more difficult. However, if marked failure of growth and chest deformity are present in a patient with mitral valve disease, this argues that the condition has been present for some years; back-calculation to height and weight ages will frequently put the individual in an age group (for example, two to four years), in which rheumatic fever is less likely.