A 49 year-old man was admitted to the hospital with complaints of productive cough, slight shortness of breath and occasional night sweats of two months' duration. There was no hemoptysis or history of previous respiratory illness. He had been a moderate smoker for 30 years. Physical examination was not remarkable and there was no cyanosis. Skin tests, cytology and cultures of bronchial washings were negative. On bronchoscopy, there was a thick exudate coming from the superior segment of the left lower lobe. The chest film revealed poorly defined consolidation of the superior segment of the left lower lobe.

**Answer:** LIPOID PNEUMONIA

Left pneumonectomy was performed. Examination of the specimen demonstrated consolidation and yellow pus in the superior segment of the left lower lobe with surrounding pleural adhesions. The surgeon felt that the lesion closely resembled that of carcinoma. Microscopically, there was marked fibrosis with acute and chronic inflammation. Lipid-filled histiocytes were present in the alveolar spaces. The diagnosis was organizing lipoid pneumonia. Further questioning of the patient disclosed that for many years he had instilled a mentholated petroleum preparation into his nostrils before going to bed.

*Department of Radiology, University of California Medical Center.*
There are no roentgenographic findings which are diagnostic of lipoid pneumonia. Two general appearances are described, the diffuse and the nodular. The former is more common and consists of widespread, ill-defined linear densities which have a “spun glass” appearance. The latter, illustrated by this case, may be well circumscribed or poorly delineated with extension of fine projections into the adjacent tissue. The disease has a predilection for the posterior segments of both lower lobes, more predominantly on the right. The lesion may closely resemble tumor both grossly and roentgenographically. In one series of 35 consecutive cases, nine were operated for suspected tumor. The microscopic appearance is usually diagnostic. A high index of suspicion is the best asset in making the diagnosis.

REFERENCES

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

PULMONARY FUNCTION STUDIES USED TO EVALUATE AIR POLLUTION ASTHMA DISABILITY

High incidence of asthma was noted in the vicinity of the city of Yokohama (in 1946, shortly after the U.S. Armed Forces began their occupation of Japan). The 1946 U.S. Army Hospital, Yokohama, Essential Technical Data Report recorded that the clinicians at that hospital were seeing an unusually large number of patients with asthma. Because of this high incidence of asthma in the area and the dramatic improvement of the patients when moved from there, the disease was popularly called “Yokohama Asthma.” Since 1950 the disease has been observed throughout the Kanto Plain (Tokyo-Yokohama region) with increasing frequency. It has become one of the major causes of morbidity among U.S. military personnel and their dependents in the area.

It is apparent from our studies that all of the patients with this disease had marked air flow obstruction. The vital capacities were usually close to normal. The air flow rates in hospitalized patients were considerably worse than those in patients who were seen only in the outpatient clinic. It was observed that many hospitalized patients were seen frequently in the outpatient clinics and had several readmissions to the hospital. Many of these patients were examined at the time of the pulmonary function studies and no wheezing could be elicited. The only evidence of the severity of the underlying disease was the history of marked shortness of breath. External spirometric pulmonary function studies provide a useful and reliable tool to determine objectively the degree of air flow obstruction manifested by shortness of breath in these patients.