The patient is a 17-year-old white woman with a four-year history of recurrent upper respiratory infections, pleuritic pain in the left anterior hemithorax and wheezing. Dyspnea, nonproductive cough and pain in the left side of the neck were noted one week prior to admission. Two days later she coughed one-fourth teaspoonful of bright red blood. Her family history was noncontributory.

Physical examination revealed that she was well developed, well nourished and did not appear ill. There was no respiratory distress, cyanosis or clubbing of the fingers. There was no abnormality noted over the lung fields or elsewhere.

*Louisiana State University, School of Medicine.
Sputa were negative for acid-fast bacilli, pyogenic organisms and fungi. Intradermal tests for tuberculosis, histoplasmosis, blastomycosis and coccidioidomycosis were negative. On bronchoscopy, the left main stem bronchus was displaced medially. Bronchial washings were normal.

**Diagnosis: Mediastinal Hemangioma**

The chest roentgenogram disclosed the presence of a well-circumscribed mass protruding into the left hemithorax from the superior mediastinum. The aortic knob was visible through the mass. The trachea was deviated slightly to the right. No intrinsic pulsation of the mass or esophageal compression was noted fluoroscopically.

Exploratory thoracotomy was performed. A cystic, multinodular mass was excised from the anterosuperior mediastinum. It was attached to the left innominate vein and incorporated the left phrenic nerve. Histologically, a diagnosis of cavernous hemangioma was made. She had an uneventful recovery.

Mediastinal hemangiomas are quite rare. They may be benign (the more common) or malignant (hemangioendothelioma). Multiple tumors are infrequent. These tumors are usually located in the anterior compartment of the mediastinum close relationship to the trachea, bronchi, and great vessels. They may give rise to signs and symptoms when compression, displacement, or invasion of these structures occur. Rarely they may become infected. Occasionally they establish a communication with the bronchial tree or pleural cavity, resulting in severe hemorrhage. Bergstrom reported two fatal cases in infants. In one, death resulted from rupture of the hemangioma into the pleural cavity. In the other, death occurred from progressive compression of the esophagus, aorta, inferior vena cava, and other mediastinal structures.

The vascular supply of these tumors usually consists only of a small afferent and efferent vessel, which probably accounts for the absence of intrinsic pulsations. Spontaneous regression may result from stenosis or thrombosis of the afferent vessel. A higher incidence (65 per cent) has been reported in females.

Differentiation from other mediastinal masses cannot be made unless the tumor contains phleboliths. These present the same roentgen appearance as in the veins of the pelvis, and are often multiple.

**References**


**Pressure Measurement in Cardiac Cavities and Large Vessels During Mitral Commissurotomy**

A total of 330 punctures of the cardiac cavities and large vessels was effected during 67 operations on the heart or mitral stenosis. For pressure measurement, the author employed an electric manometer from the apparatus for cardiac catheterization, elaborated by the Scientific Research Institute of Experimental Surgical Apparatus and Instruments. Not a single serious complication associated with the puncture was recorded. Almost in all cases puncture of the heart called forth individual or group extrasystoles. A short-term paroxysmal tachycardia during puncture of the left atrium was noted only in three patients. Puncture of the aorta and pulmonary artery did not cause rhythm disorders, but almost always it was attended by the formation of hemorrhages around the vessels. No bleeding is observed after extraction of the needle from the heart cavity. Immediately after dilatation of the mitral orifice, there is seen a decrease of pressure in the pulmonary artery and a sharp drop of pressure in the left atrium. The greatest drop of pressure in the left atrium and even normalization thereof was observed in the group of patients with a more complete dilatation of the orifice. When the interference was not radical, the pressure remained considerably elevated.