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CLINICAL INFORMATION

This 22-year-old Negro sought hospitalization because of slight cough, mucoid sputum, and five pound weight loss. A sister had inactive tuberculosis, but his tuberculin test was negative. Physical examination was entirely normal.

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Diagnosis: Sarcoidosis

Scalene lymph node biopsy was compatible with sarcoidosis. The uveal tract was normal. Roentgenograms of the hands and feet were normal. No therapy was given. Figure 2 is a chest film taken seven years after Fig. 1, and reveals marked spontaneous regression of the pulmonary lesions.

Sarcoid occurs most commonly in young adults, and in the United States the Negro is affected about 15 times more frequently than the Caucasian. The tuberculin skin test is negative in from 80 to 90 per cent of cases. Lesions have been found in practically every organ of the body at one time or another. Patients are frequently asymptomatic and the diagnosis is often first suggested from a routine chest film (in 67 per cent of the patients in one series).

The roentgenogram may show disseminated bilateral miliary or coarsely nodular lesions or reticulated linear strands. The disseminated large fluffy nodules seen in Figure 1 are virtually diagnostic. Lymphadenopathy is usually seen (76 per cent in one series). In some cases hilar adenopathy develops before the pulmonary infiltration. The pulmonary lesions, when they regress, clear slowly. Resorption of chronic interstitial fibrosis, however, rarely if ever occurs.

Smellie and Hoyle described the roentgen course of untreated patients and found that of 77 patients with pulmonary lesions, 51 per cent cleared, 10 per cent improved, 12 per cent were unchanged and 27 per cent progressed (five died). Of 41 patients with hilar node involvement, 61 per cent cleared, 10 per cent improved, 7 per cent were unchanged, and 22 per cent became worse (two died). The cases with the best prognosis seemed to be those with erythema nodosum and those with hilar adenopathy and normal lung fields. They noted that if pulmonary infiltration persists for two years, it is unlikely to remit spontaneously.

References


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SEPTAL DEFECT DUE TO TRAUMA

A report of successful closure of a traumatically acquired interventricular septal defect is made. The lesion followed a nonpenetrating steering-wheel injury of the chest. The diagnosis was made clinically and confirmed by cardiac catheterization. Complete repair, confirmed by postoperative catheterization, was followed by complete recovery. An interesting feature of this particular traumatically acquired defect was that it occurred in the muscular portion of the ventricular septum, distant from the valves and also from important conduction fibers. This made surgical repair technically more facile and safer for the patient than repair of a congenital defect. The benign course of the patient may have been related to his youth and previous health, the moderate size of the defect, the likely partial closure by healing and his immobilization during convalescence by leg fractures. Surgical repair in this case was elective and could await maximal recovery. When heart failure occurs in the presence of a large defect or poor cardiac reserve, early closure may be indicated.


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MYOCARDIAL FIBROSIS SIMULATING MITRAL STENOSIS

A case of a 32-year-old woman with myocardial fibrosis on the left ventricle is reported. The patient was operated under the clinical diagnosis of mitral stenosis. Only the clinical course and the changing alterations of the electrocardiogram gave indication of this rare diagnosis.