Mediastinum and Lung Fields

Cap of Zinn = large thymus or dilated pulmonary artery with persistent ductus arteriosus.
Sail = thymus.
Spinnaker sail = pneumomediastinum.
Smudge = tuberculosis.
Tennis racket = tuberculous cavity.
Coin = solitary pulmonary nodule (less than 5-6 cm diameter).
Pop-corn; mulberry = hamartoma.
Honeycomb; net = bronchoalveolar emphysema (staphylococcal pneumatoceles, eosinophilic granuloma, collagen diseases, etc.)
Soap bubble = bullous emphysema.
Rat tail = bronchogenic carcinoma.
Golf ball; cannon ball = “large” pulmonary metastases.
Butterfly wing; bat wing = pulmonary edema.
Spider’s web = pulmonary lymphangitis or lymphangiectasis.
Water lily = collapsed hydatid cyst membrane.
Mouse = calcified pleural hematoma.
Gloved finger; pruned tree; leafless tree = bronchiectasis (bronchography).
Smear; mold; fork = esophageal leiomyoma (barium swallow).

Ribs and Vertebrae

Soap bubble = fibrous dysplasia.
Dripping candle = “melorheostosis”.
Moth-eaten = multiple myeloma; metastases.
Onion skin = Ewing’s tumor.

Pleas for better medical communication have been voiced sporadically.1-8 In fact, a whole series of articles in the Journal of the American Medical Association are currently dedicated to that very purpose. Surely our colleagues in radiology would be remiss in using an idiom the imprecision and confusing aspects of which may inadvertently derogate proper patient care because of misunderstanding! Those who persist in such a practice become unwitting emulators of yet another Lewis Carroll character—

“When I use a word,” Humpty Dumpty said, in rather a scornful tone, “it means just what I choose it to mean—neither more nor less.”

“The question is,” said Alice, “whether you can make words mean so many different things.” “The question is,” said Humpty Dumpty, “which is to be master—that’s all.”

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References


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Clinical Studies of Coronary Arteriography

If the clinical value of selective cine-coronary arteriography is assessed fully, the standards for clinical electrocardiographic and arteriographic classification must be defined. Coronary disease is not a single entity but a group of clinical syndromes, each of which must be described clearly. The duration of the symptoms is probably important also. Electrocardiographic criteria require rigid definition. Myocardial infarction may be described variously. The other abnormalities in the electrocardiogram, which are less specific for coronary disease, should be defined carefully. Coronary disease is an arterial disease, so it should not be surprising that the resting electrocardiogram does not correlate well with the arteriographic findings. A uniform method of classification of degree of arterial obstruction would be helpful. The poor quality of arteriograms in many laboratories limits interpretation.

Surviving patients are studied arteriographically and obstructive lesions are demonstrated at some stage of the clinical disease, rather than the end result. Therefore, it is difficult to correlate arteriographic and postmortem findings, assuming that the latter accurately reflect the status of the circulation just before death.

For clinical investigation, a group of patients studied by arteriographic means must be classified by specific clinical diagnoses and these diagnoses correlated with the arteriographic findings. Some patients will have no obstructive lesions. Those who have no hypertension, lesions which limit the cardiac output, and no valvular disease may complain of pain of anginal type in the absence of any obstructions that can be demonstrated arteriographically. These constitute a very small percentage of patients who complain of anginal type pain. It is likely that the pain was of non-cardiac origin. In no field of medicine is there a higher correlation between the clinical diagnosis and an objective method of demonstration of disease.

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