PROGRESSIVE CONGENITAL VALVULAR AORTIC STENOSIS

REFERENCES

of carcinosarcoma considered a noma. Stackhouse and associates, reviewing eight cases of pulmonary blastoma, stated that these cases should be considered as a distinctive group or subclassification of carcinosarcoma which simulates immature or developing lung blastema. Although more detail of differences in histogenesis of these two varieties of rare pulmonary tumors are given by others, it is important to recall that carcinosarcoma arises from cells of two separate germ layers, whereas pulmonary blastoma develops from a pleuripotential cell of a single germ layer.

The benign or malignant nature of this tumor still remains mysterious. However, after reviewing the literature, it seems reasonable to postulate that it is the metastatic nature of this neoplasm which causes the very poor prognosis. The size of these lesions bears no relation to the extent of metastases and subsequently to ultimate outcome of these patients.

The treatment of choice, from the available data, seems to be surgical intervention unless the risk of operation is considered hazardous to the life of the patient.

ADDENDUM

The patient was last seen on April 1, 1971, 16 months after operation. He is completely free of symptoms and his chest x-ray film shows negative findings.

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Progressive Congenital Valvar
Aortic Stenosis*

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Repeat cardiac catheterization in a 12-year-old boy (previously shown to have mild valvar aortic stenosis at five years of age) revealed development of severe stenosis, thus reaffirming the need for careful follow-up studies in patients with mild congenital valvar aortic stenosis.

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although there have been several reports1-4 regarding the clinical course of mild congenital aortic valvar stenosis, to date there have been few published articles of patients followed-up with serial cardiac catheterizations to determine whether the stenosis changes in severity with growth of the subject. We have recently seen a 12-year-old boy, proved by cardiac catheterization to have mild aortic valvar stenosis at age five years, who on repeat catheterization seven years later was found to have progressed to severe aortic stenosis.

CASE REPORT

Our patient was the product of an uncomplicated pregnancy and delivery and weighed 3,340 gm at birth. Heart murmur was detected at six weeks of age. He was first seen at Colorado General Hospital at four years of age, at which time he was asymptomatic. Physical examination revealed a systolic thrill in the suprasternal notch, a systolic ejection click and a grade 4/6 systolic ejection murmur. Diastole was clear and no other murmur or extra heart sound was heard. No lift of left ventricle was noted. At cardiac fluoroscopy, the overall heart size was normal; however, in the left anterior

Figure 1. The QRS voltage is consistent with left ventricular hypertrophy. Early repolarization can be seen in several leads (normal standardization, 1 millivolt-10 mm deflection).

Figure 2. As compared to the tracing of 1960, the QRS voltage has increased in both the frontal and precordial leads and minor ST segment and T wave changes have appeared.
oblique view, there was slight left ventricular prominence and dilatation of the ascending aorta. The electrocardiogram (Fig 1) revealed the QRS voltage to be in slight excess of normal, but was otherwise not remarkable.

At five years of age, following premedication with meperidine (Demerol 1 mg/kg) and secobarbital (Seconal 4 mg/kg), left heart catheterization was performed using the Ross transseptal technique. Pressures in the right side of the heart were normal. Left heart catheterization revealed a resting peak systolic gradient across the aortic valve of 21 mm Hg with a normal left ventricular pressure of 121/0-12 and a central aortic pressure of 100/84. The calculated valve area was 1.14 cm²/M² (normal 1.7 to 1.9 cm²/M²). Although the patient remained asymptomatic, at age 12 years the physical findings suggested severe aortic valvular stenosis (prominent lift of left ventricle present) and the electrocardiogram (Fig 2) revealed an increase in QRS voltage and minor ST and T wave changes. The chest x-ray film revealed no significant change as compared to previous films. Thus, a second cardiac catheterization was performed. Following premedication with the same two drugs, retrograde left heart catheterization was performed which revealed a resting peak systolic gradient across the aortic valve of 103 mm Hg with markedly elevated left ventricular systolic and end-diastolic pressures of 190/0-21 and a central aortic pressure of 87/65. The calculated aortic valve area was 0.39 cm²/M². Aortic commissurotomy was recommended, and at the time of surgery, four months later, the patient was found to have a severely stenosed bicuspid aortic valve. Commisurotomy was performed and the patient's postoperative course has been uncomplicated.
Lung Abscess Secondary to Vibrio Fetus, Malabsorption Syndrome and Acquired Agammaglobulinemia

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A patient who had severe acquired hypogammaglobulinemia, carcinoma in situ of the stomach, malabsorption syndrome, prolonged Vibrio fetus bacteremia, recurrent thrombophlebitis and lung abscess is presented. We discuss the association of impaired antibody production and infection with an organism requiring cellular immunity for protection.

Vibrio fetus has recently been recognized as a not uncommon pathogen for man. Although this Gram-negative bacillus was recognized as a cause of contagious abortion in cattle as early as the first decade of this century, the first instance of definite human infection was not reported in the English literature until 1948. Since that time, about 50 reports of human disease have appeared. This organism is of special interest since it seems to share with certain bacteria such as Listeria, Salmonella, Brucella, and Mycobacteria, the capability of living within the host as an intracellular parasite for prolonged periods of time. This report concerns a patient with acquired immunoglobulin deficiency, thrombophlebitis, severe malabsorption, lung abscess, a relapsing febrile illness, postmortem findings of gastric carcinoma (in situ), and blood cultures which were positive for Vibrio fetus for more than a month.

Case Report

A 56-year-old white married woman was admitted to Presbyterian-St. Luke's Hospital for the 11th time on May 16, 1968. She had a history of frequent upper respiratory infections and sinusitis since early adulthood. In 1954, she experienced diarrhea, characterized by frequent, loose, foul-smelling stools which floated and seven years later was found to have a markedly reduced total protein of 3.5 gm percent with a gammaglobulin of .1 gm percent determined by protein electrophoresis. The pertinent studies at this time were compatible with a malabsorptive state and also demonstrated the presence of Salmonella derby in the stool.

Small bowel biopsy was read as adult celiac disease. She was put on a gluten-free diet with some improvement in her symptoms, but a subsequent biopsy showed no histologic improvement. During the years between 1963 and 1967, she was admitted several times with recurrent pulmonary infections, and symptoms secondary to her malabsorption. Quantitative immuno-electrophoresis by method of Heremans revealed an absence of IgG (Table 1). Skin tests with tuberculin, fungal and mumps antigens were negative, and there was no antibody rise to challenge with typhoid and tetanus antigens. In 1964, a skin homotransplant was done and at 25 days, the graft was described as being "75 percent rejected." Salmonella derby was isolated from her stool on several occasions during 1963 and 1964, but never after that time.