Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Specific permission to publish should be cited in a covering letter or appended as a postscript.

**Combined Apical Hypertrophic Cardiomyopathy and Coronary Artery-Left Ventricular Fistula**

To the Editor:

Combined hypertrophic cardiomyopathy with coronary arteriovenous fistula is extremely rare. We report a unique patient who presented with apical hypertrophic cardiomyopathy associated with coronary artery-left ventricular fistula.

A 50-year-old Chinese man was referred for evaluation of chest pain. Clinical examination revealed a blood pressure of 130/60 mm Hg. No murmur was heard in the precordium. Mild cardiomegaly was seen on chest x-ray film. The 12-lead electrocardiogram showed tall R waves in leads V2 and V3, and deep T wave inversion in the precordial leads, especially in leads V3 and V4. Two-dimensional echocardiography revealed apical hypertrophic cardiomyopathy. Left heart catheterization and selective coronary angiography was then performed. This showed bilateral coronary artery-left ventricular fistula and apical hypertrophic cardiomyopathy (Fig 1).

Up to 1984, only three cases of combined hypertrophic cardiomyopathy with coronary arteriovenous fistula were reported in the literature. Interestingly, in all three cases the coronary fistula communicated with the pulmonary artery. Apical hypertrophic cardiomyopathy is relatively uncommon in the West but is frequent in Japan. Of all the coronary arteriovenous fistulae, coronary artery-left ventricular fistula is the rarest, seen in about 2 percent of cases. As of 1981, only 23 cases of coronary artery-left ventricular fistulae have been reported. However, the combination of apical hypertrophic cardiomyopathy and coronary artery-left ventricular fistula has not been previously described.

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**REFERENCES**


**Atypical Roentgenographic Manifestations of Pneumocystis carinii Pneumonia in AIDS**

To the Editor:

We found the article by DeLorenzo et al1 of great interest. In this article, the radiologic manifestations of a group of patients with acquired immune deficiency syndrome (AIDS) and Pneumocystis carinii pneumonia (PCP) were analyzed. Although the classic bilateral alveolar or interstitial patterns were most frequently encountered, the authors also pointed out other atypical patterns that could develop in these patients, such as localized infiltrates, cystic or honeycomb lesions, hilar enlargement and spontaneous pneumothorax.

In the case of a drug addict with AIDS and PCP which we previously published,4 the radiologic presentation was also very atypical. Initial X-ray films showed lung abscess with an air-fluid level localized in the lower left lobe with ipsilateral pleural effusion. Pneumocystis carinii cysts were detected in a specimen obtained by transthoracic lung needle aspiration; bacterial, mycobacterial, and fungal cultures of this sample were negative, as well as direct immunofluorescence staining for Legionella pneumophila (DFA).

The mechanism by which the Pneumocystis carinii infection could have brought about a lung abscess in our patient is unclear, since this microorganism does not appear to have sufficient necrotizing capacity of the lung parenchyma. Several infections (bacterial, mycobacterial, fungal) which are frequently encountered in these