a few days, and he has remained asymptomatic for the last three years. A second bronchoscopy, performed one month after the first, revealed a normal appearing bronchial stump.

**DISCUSSION**

Although localized Aspergillus infestation sometimes has been described in lung neoplasms,\(^7\) no evidence of tumor relapse was found in our case.

Most knowledge about BSA derives from the experimental and clinical study performed by Sawasaki et al.\(^8\) These authors showed that the incidence of this peculiar manifestation of Aspergillus infection was 1.5 percent when silk was used as the endobronchial suture in pulmonary resection. An extremely high incidence (24.6 percent) of local inflammation around silk thread also was pointed out, in contrast with the rarity of such bronchoscopic findings when the suture material was nylon (5.7 percent). The specific tropism of Aspergillus for tissues with poor viability, in spite of good drainage, already has been reported in some studies.\(^8,10\)

Besides local inflammation, it has been stated that the distinctive high capillarity of silk thread favors local infection by Aspergillus.\(^9\) Interestingly, among the nine cases reported by Sawasaki et al.,\(^8\) the period from the operation to the onset of disease usually ranged from 6 to 12 months; in only one case the symptom-free interval was 3 years and 2 months.\(^9\) To the best of our knowledge, such a long latency period as that observed in our case has not been reported.

Silk thread was widely used by thoracic surgeons until some years ago, and it has been progressively replaced by newer materials. However, it must be kept in mind that a long symptom-free interval, such as that in our case, may occur in BSA. Unlike most pulmonary manifestations of Aspergillus, BSA usually has been reported in patients with no apparent immunocompromise.\(^9\) Interestingly, BSA has been considered the pathogenic cause of some cases of Aspergillus empyema.\(^11\) Therefore, besides the usual clinical features of cough and hemoptysis directly caused by this entity, lack of proper diagnosis may imply long-term complications in postsurgical patients.

It is worthwhile to emphasize that simple removal of the suture is likely to be the therapy of choice in BSA, considering the optimal follow-up in our case with just suture removal and the potentially harmful side effects of many antymycotic therapies. Although Sawasaki et al.\(^8\) advocated the administration of topical or systemic antifungal therapy, the results of this therapy cannot be validated by their own findings since no control group was included in the study.

**REFERENCES**


**Giant Aneurysm of the Ascending Aorta Secondary to Medial Agenesis in Infancy**

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A 14-month-old infant was found to have a giant aneurysm of the ascending aorta at the time he underwent angiography. At the time of autopsy, a saccular chamber was found to take the place of the aorta. Histologic examination of the aneurysm revealed absence of the medial layer. Thus, medial genesis may be another cause of aneurysm of the ascending aorta.

(Chest 1993; 104:296-97)

**Arterial aneurysms secondary to medial agenesis are rare.**

The brain arteries are more frequently affected, but peripheral arteries may be involved as well.\(^1,4\) As far as we know, medial agenesis has never been found in association with aneurysm of the ascending aorta.

**CASE REPORT**

A 14-month-old white male infant was admitted to our institution because of intractable heart failure. He developed dyspnea on effort, pallor, and irritability when he was four months old. At that time, the infant was treated with digitalis and diuretics with good results. He remained well until one week prior to admission, when dyspnea at rest and nocturnal paroxysmal dyspnea appeared. There was no history of viral infection or familial cardiomyopathy.

The abnormalities detected at the time of physical examination were pallor, a heart rate of 150 beats per minute, and a liver palpable 3 cm below the right costal margin. The remaining results of physical examination were normal.

A chest x-ray film revealed marked cardiomegaly associated with pulmonary vascular congestion. The resting ECG showed paired of premature ventricular contractions, a pathologic Q wave in the anterior site, and diffuse ST-T segment alterations. Two-dimensional echocardiography showed left ventricular dilatation, moderate depression of left ventricular contractility, and remarkable dilatation

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patients had multiple peripheral aneurysms without involvement of the ascending aorta.

In the present case, the aneurysm of the ascending aorta was associated with severe heart failure. In most cases, aneurysm of the ascending aorta induces heart failure through a marked aortic regurgitation. However, both angiography and postmortem examination performed on our patient failed to reveal any abnormality in the aortic valve. Neri et al recently have described a case of an 81-year-old patient in whom a giant aneurysm of both the thoracic and the abdominal aorta compressed the left atrium and obstructed the diastolic filling of the left ventricle. In the patient reported in this article, a huge aneurysm of the ascending aorta displaced both atria laterally. It is conceivable that this fact might have interfered with blood flow through the atria, thus causing chronic heart failure.

It has been postulated that medial agenesis may be the consequence of either embryogenic ischemia or alterations of collagenase and copper metabolism. Whether a similar mechanism caused the aneurysm of the ascending aorta observed in our patient remains to be determined.

In conclusion, this case shows that medial agenesis may be another cause of aneurysm of the ascending aorta in infancy.

ACKNOWLEDGMENTS: The authors wish to thank Drs. Marcelo Zanardi and Clemente Greguolo for referring the patient for consultation and Dr. Dair Kiomi Kazawa for his help with the pathologic documentation.

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