The initial examination was made on May 17, 1949. The history of symptoms began in September 1948 with coryza. The coryza improved, but a definite residual "hoarseness" became apparent, which was associated with a slight, "tickling" cough that gradually became productive in the course of several months. The mucus was tenacious, of yellow color and devoid of blood. The cough had progressed in severity and frequency and had been paralleled with progressive dyspnea and a sense of substernal pressure and burning in the inspiratory phase. However the appetite had remained unimpaired, and there had been no apparent loss of weight.

The temperature was normal; pulse rate, 96; respiratory rate, 32; blood pressure, 150/70. The weight was 169 lb. (76.5 Kg.); the height, 62½ in. (159 cm.). The vital capacity was read at 1.0 l. and computed at 32 per cent of the estimated normal. The patient exhibited severe dyspnea at rest. Pronounced acrocyanosis was noted. The finger tip contour was normal. There was no pulmonary osteoarthropathy.

Definite limitation of thoracic motions was evident. The patient complained of substernal pain on relatively mild inspiratory effort. Percussion tone was resonant throughout. Basal sibilant rhonchi were present.

Pulmonary roentgenograms taken on May 18, 1949 revealed a diffuse granular involvement of the lung fields. The pattern indicated a diagnosis of chronic pulmonary granulomatosis. Roentgenograms of the hands did not disclose osseous abnormalities such as those sometimes seen in Boeck's sarcoidosis.

The patient was examined at rather frequent intervals for progress of the disease. On Nov. 29, 1949 clinical studies on a blood sample gave the following results: red blood count, 5,300,000; hemoglobin, 100 per cent; white cell count, 12,150, with normal differential percentages; total serum protein, 7.2 mg. per 100 cc., with an albumin-globulin ratio of 1.7: 1. Urinalysis gave essentially negative results.

As the patient's symptoms became progressively aggravated, hospitalization for oxygen therapy became necessary on May 8, 1950. Until this time her mental outlook had been fairly optimistic and her cooperative spirit exceptional.

The admission examination revealed a rather well nourished but mentally depressed white woman, 62½ in. in height and weighing 160 lb. (12.5 Kg.). Spasmodic coughing was almost constant throughout the examination. Constant high concentration of oxygen was necessary for the purpose of maintaining some degree of comfort. The respiratory rate was 48 per minute. Despite the oxygen therapy, pronounced acrocyanosis was apparent. The finger nails showed early evidence of "watch glass" curving. Cardiac dulness was beyond normal limits bilaterally; the cardiac rate was 120 and the blood pressure 150/82. Thoracic motion was markedly limited. The percussion tone was resonant throughout. Auscultation revealed inspiratory sibilant rhonchi throughout. Moist rales were discerned at the bases posteriorly.

A pulmonary roentgenogram taken on May 10, 1950 revealed the same nodular and granular pattern of the parenchyma as previously described. Enlargement of the cardiac silhouette was evident.

Laboratory observations on admission were as follows: red blood cell count, 4,140,000; hemoglobin, 80 per cent; white blood cell count, 10,250, with normal differential percentages; total serum protein, 10.4 mg., with an albumin-globulin ratio of 1.3: 1. Numerous urinalyses gave essentially negative results throughout her hospital stay. On September 27 the red blood cell count was 4,520,000, the hemoglobin 94 per cent and the white blood cell count 10,950, with a normal differential count.

Approximately 4 Gm. of cortisone acetate was administered between June 4 and 16, without any appreciable clinical response. Almost constant utilization of oxygen was necessary to relieve dyspnea and cyanosis. Because of appreciable right-sided cardiac failure with evidence of decompensation, meralluride injection U. S. P. (mercuhydrin® sodium solution) and digitalis were administered, with some therapeutic response, as indicated by clearing of peripheral edema.

On July 28 ACTH therapy was instituted. Until the date of hospital discharge, two months later, the patient had received more than 3 Gm. of the drug. She has been on a daily maintenance dose of 20 mg. of the drug to date.

In addition to cortisone and ACTH therapy, the patient received 12,000,000 units of penicillin between May 14 and June 3 and also 10 Gm. of chloramphenicol (chloromycetin®) between July 24 and August 3. No apparent clinical improvement resulted from the use of the latter two drugs.