In October 1947 he first became aware of a refractive spasmodic productive cough, progressive exertional dyspnea and anorexia with associated loss of weight.

The paroxysmal cough gradually increased in intensity and frequency, and in the expectorated mucus a greenish tinge developed. Exertional dyspnea and anorexia became pronounced. Eventually, in March 1948, the severity of the symptoms forced him to forego all physical work.

During the first two years of the disease the coughing paroxysms were associated with vertigo. Frequent attacks of "mild chills" and fever were experienced during the first few months following the onset and to a lesser degree up to the time of hospitalization in August 1950.

The patient was referred for consultation on April 26, 1948 after interpretation of a pulmonary roentgenogram. His temperature was normal; pulse rate, 75; respiratory rate, 20; blood pressure, 95/70. The vital capacity was read at 3.4 l. and computed as 82 per cent of the expected normal. The breath-holding time was 20 seconds.

The patient did not appear acutely ill. Respiratory distress was not apparent at rest, nor was acrocyanosis present.

There was an equal thoracic limitation of motion on forced inspiratory effort, during which time the patient complained of substernal pain. Percussion tone was unimpaired. No abnormalities were detected on auscultation.

A pulmonary roentgenogram taken on April 13, 1948 revealed a diffuse granular involvement throughout the parenchyma of both lung fields. There was an associated prominence of hilar shadows without nodulation. Roentgenograms of the hands failed to show any osseous changes. Clinical studies on blood and urine demonstrated that these were essentially normal. A diagnosis of chronic pulmonary granulomatosis occurring in a beryllium worker was made.

The patient has been examined at regular and frequent intervals for the progress of the disease. Specialized studies were conducted at the University of Rochester School of Medicine in the fall of 1948.

Despite varied and intensive supportive therapy since the initial examination, the patient became progressively worse and consequently was hospitalized on Aug. 15, 1950.

The admission examination revealed a severely emaciated, mentally depressed patient exhibiting dyspnea at rest. Spasmodic coughing was pronounced during the entire examination.

The blood pressure was 110/74. The weight was 120 lb. (54.5 Kg.), a 60 lb. (27 Kg.) loss since the onset of symptoms in 1947. The vital capacity was read at 2.0 l. and computed as 48 per cent of the expected normal. Acrocyanosis and early clubbing of the finger tips were noticed. There was definite limitation of thoracic motion. The percussion tone was resonant throughout, and sibilant rhonchi were present at both bases.

A pulmonary roentgenogram taken on Aug. 19, 1950 revealed the previously described pattern plus a suggestive honeycomb appearance of the upper part of each lung field.

Three days previously ACTH therapy had been started. Up to Sept. 7, 1950, the date of hospital discharge, he received a total of 1,300 mg. of the corticotropin. A maintenance dose of 20 mg. per diem is currently prescribed.

Roentgenograms taken on September 1 failed to reveal any appreciable change in the pattern. During the period of hospitalization several clinical blood studies and numerous urinalyses failed to disclose significant abnormalities. The temperature range was within normal limits, the pulse ranged between 80 and 100, and the respiratory rate between 20 and 30.

During the three weeks of hospitalization the patient began to manifest an excellent appetite and gained 8 lb. (3.5 Kg.). The mental outlook was definitely improved. Dyspnea and the frequency of coughing paroxysms were reduced.

The last examination prior to this report was made on October 11. The patient had increased his weight to 132 lb. (60 Kg.) and his vital capacity to 2.4 l.

CASE 2.—A white woman, now 70 years of age, was referred in May 1950 for consultation on the basis of the interpretation of a pulmonary roentgenogram.

The history of beryllium exposure was rather meager. In 1941 she had resided two standard city blocks southwest of a beryllium production plant. From 1942 until the present time she has resided eight to nine blocks directly south of the same plant. No history of coming into either direct or indirect contact with workers at the plant could be established. The patient did assert that when living in the immediate area she was conscious of fumes which caused coughing, especially at night.