

the left, enlargement of the spleen and the suggestion of a retroperitoneal mass rotating the left kidney. Three attempted thoracenteses failed to encounter fluid, although the needle was inserted to a depth of 5 cm. No acid-fast organisms were found in the sputum. Tuberculin tests were negative in a 1:1000 dilution. The patient became ex-

the final hospital admission, with fever for a week. About 1000 cc. of fluid was removed, following which the patient was discharged from the hospital. He then rested at home for four months, returned to work and remained in good condition for a year. This could have been pleurisy with effusion, perhaps tuberculous. Many sputum examinations, however,

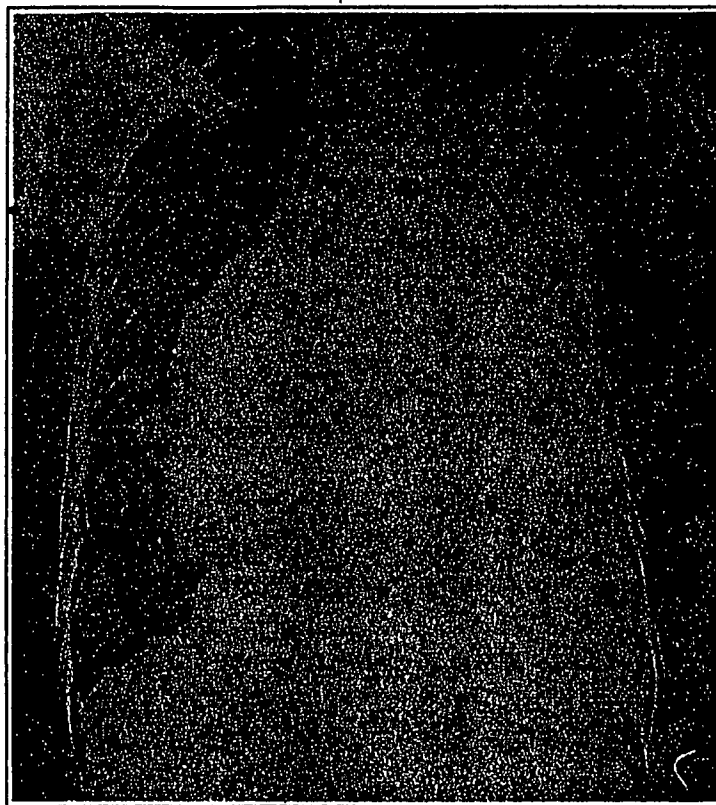


FIGURE 1. Roentgenogram of the Chest, Showing Opacity on the Left and Multiple Nodules in the Right Lung.

tremely weak and dyspneic and perspired constantly. He died on the thirty-seventh hospital day.

DIFFERENTIAL DIAGNOSIS

DR. DONALD S. KING: This seems to be the old problem of a tumor in the lung with a decision to be made regarding the kind of tumor. As in most cases, the decision will be based largely on the x-ray appearance.

One should comment first on the occupation. This man worked with asbestos, cutting insulating board. Exposure to asbestos causes lung changes but never, in my experience, to the extent that was present in this case. I believe that asbestosis was not a factor in the illness and that, if present, it was of secondary importance.

The next question concerns tuberculosis. The onset of the disease was two and a half years before

showed no tubercle bacilli, and shortly before death a tuberculin skin test was negative in a 1:1000 dilution. In any event, the evidence for tuberculosis does not seem sufficient to justify that diagnosis in addition to what I believe was a tumor. My diagnosis is tumor, with fluid that was secondary to the tumor and not due to tuberculosis or other infection.

The x-ray films present a different picture on each side of the chest. On the right side there are many nodules, which are better shown in some films than others. In my experience, rounded nodular shadows of this sort have always been caused by metastatic tumor, either from some spot elsewhere in the lung or from some place outside the chest. If the tumor was metastatic from outside the lung, it could have been from above the clavicles or below the diaphragm, or there could have been metastases from a primary bronchiogenic cancer in