

The clinical symptoms were dyspnea on effort and persistent unproductive cough, attributable to silicosis, which lately was associated with sudden pain in the right axillary region and with dyspnea at rest, for which the spontaneous pneumothorax was responsible.

Roentgen examination revealed pronounced diffuse emphysema, which was particularly manifest at the bases. Bubbles the size of large hazelnuts were noticeable at the right side, in the subclavicular region and in the middle field, and there were ringlike shadows and limited zones of great transparency with a fine border in the right subclavicular region.

It is suggested that parenchymal and bronchial changes modified the perviousness of the respiratory tract and the elasticity of the pulmonary tissue. Bronchial obstruction prevented the inhaled air from being exhaled. Circular cavities of various sizes originated from rupture of alveoli, and spontaneous rupture of a bulla, due to pleural adhesions or congenital or acquired fragility of the pleura, determined the spontaneous pneumothorax. According to the authors, bullous emphysema has been demonstrated roentgenologically only in rare instances.

TEST OF CARDIORESPIRATORY FUNCTION IN SILICOSIS. L. PARMEGGIANI, *Med. lavoro* 41:191 (June-July) 1950.

Parmeggiani tested cardiorespiratory function in 398 patients with silicosis. The test consisted in measuring the rate of the pulse, the rate of breathing and the changes of the arterial blood pressure every minute from the moment in which the patients stopped after climbing 60 steps in from 20 to 50 seconds up to the time when the aforementioned values become normal. The ratio between the rate of the pulse and the rate of breathing at rest varied from 3 to 3.9 in 51 out of every 100 patients, from 4 to 4.9 in 24 out of every 100 and from 2 to 2.9 in 23 out of every 100. After physical effort the ratio remained constant in 29 per 100 cases, and varied slightly in 37 per 100, generally increasing. This exercise test in silicotics may be used in the evaluation of the degree of disability, through the duration of time necessary for return to normal values. In the moderate cases of silicosis it is of no significant value.

DERMATITIS FROM CONTACT WITH STREPTOMYCIN. A. SANTOS ALMEIDA, *Alergia* 4:41 (July-Oct.) 1950.

Santos Almeida reports that dermatologic lesions developed in four of 12 nurses as the result of contact with streptomycin. In one the lesions were severe, in two moderate and in one mild. They were similar, differing only in extension and severity. There was desquamative erythema, particularly of the eyelids and of the hands, frequently with interdigital fissures. The lesions appeared some time after the nurses commenced to handle streptomycin, subsided when contact with the drug was avoided, but reappeared when work with the drug was resumed. Streptomycin patch tests were positive. As prophylactic measures, the author recommends investigating former allergic disorders of nurses before they are accepted in hospitals for tuberculous patients, wearing gloves while handling streptomycin, rotating nurses in various hospital services and removing them from contact with the drug.

ALLERGIC SYNDROMES AS OCCUPATIONAL DISEASES. J. MARTORELLI, *Alergia* 4:53 (July-Oct.) 1950.

In connection with the case of a worker in a bread and cracker factory, in whom lesions of the skin and bronchial asthma developed, Martorelli discusses the medicolegal aspects of allergic syndromes. According to Law 6,988 of Argentina, an allergic syndrome constitutes an occupational disease whenever it develops in connection with an occupation.

INDUSTRIAL DISEASES OF BLOOD AND BLOOD-FORMING ORGANS. D. PARREIRAS, *Med. depor. y trab.* 14:3090 (Jan.) 1950.

Parreiras discusses the main physical and chemical causal factors of either professional or industrial erythrocytosis and leukoblastosis.