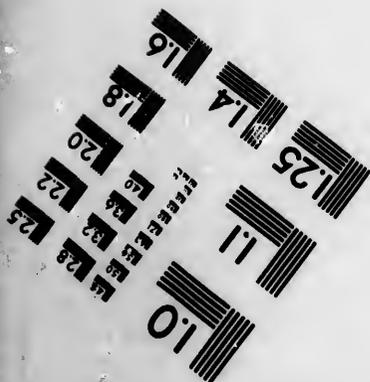
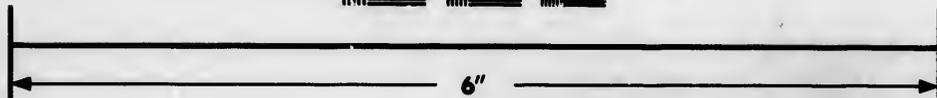
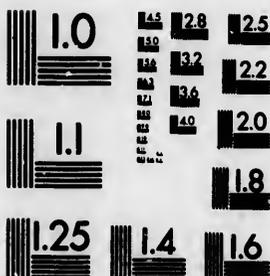


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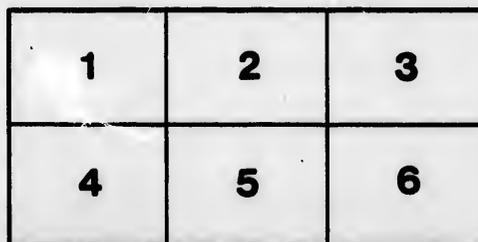
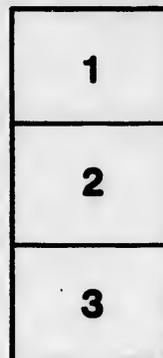
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**BRONCHIECTASIS TERMINATING IN PNEUMONIA, SIMULATING PULMONARY
AND LARYNGEAL TUBERCULOSIS.**

BY

F. G. FINLEY, M.D.,

Assistant Professor of Medicine and Associate Professor of Clinical Medicine, McGill
University; Physician to the Montreal General Hospital.

(Reprinted from Montreal Medical Journal, February, 1898)



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C. O., male, æt. 19, was admitted to the Montreal General Hospital on February 23, 1897, complaining of cough, loss of flesh and spitting of blood.

He had measles and whooping cough in childhood, and since the age of 8 years has suffered from cough, which has continued with more or less severity since. In September last it became worse, and he began to lose flesh. In January he suffered from a pain in the left side, which was extremely severe and catching at first, and lasted eight or ten days. On the day previous to admission, he spat up two or three drachms of clotted blood, and a little later a small quantity mixed with sputum.

Examination.—The patient is of medium size, fairly nourished and not anæmic and the temperature normal. There is a slight lateral curvature of the spine, the convexity being to the right in the dorsal region. The right side of the chest is rather larger, measuring $16\frac{1}{2}$ to 18 in., whilst the left is only $15\frac{1}{2}$ to 17 in. The percussion note is slightly dull on the left side in front and in the axilla, whilst it is hyper-resonant over the right lung. The breath sounds are slightly feeble over the dull area, and there are here a few scattered single crepitant râles.

The heart is of normal size; a harsh systolic murmur is present in the pulmonary area, but there is no pulmonary accentuation. There is also a systolic murmur in the left supra-clavicular area. Until February 28th the expectoration was small in quantity, the temperature did not rise above 99° , and there was slight sweating.

On February 28th the temperature rose to $102\frac{1}{2}$, the cough became severe and the expectoration copious, and a few days later extremely fetid.

From this time there was a steady downward progress. The temperature was remitting, rising from 102° to 104° at night and falling to 99° and 101° in the morning. He became pale and lost about three

lbs. weekly in weight. The expectoration increased, varying from 8 to 14 oz. daily, continuing extremely offensive. Profuse sweating was also noted. Coarse crepitant râles developed on both sides, and on March 12th, there was a dullness from the 4th to 6th rib, and in the lower axilla on the right side. Blowing breathing and bronchophony were present over the dull area. Evidence of consolidation ultimately spread over the whole posterior surface of the right lung.

Dr. Birkett examined the throat and reported marked anæmia of the soft palate and atrophic rhinitis and superficial ulceration of both the cords.

The sputum was examined repeatedly for tubercle bacilli, but they were never present.

Marked prostration of strength, slight wandering, and, on the night of his death (April 3), wild delirium preceded the fatal issue.

Autopsy—Performed by Dr. Wyatt Johnston, April 4, 1897.

Anatomical Diagnosis.—Chronic putrid bronchitis and bronchiectasis with multiple dissecting pneumonia; great enlargement of bronchial glands; chronic catarrhal ulceration of larynx; cloudy swelling of kidney.

Somewhat emaciated young man.

Rigidity present in all parts; lividity slight.

Abdomen.—Well marked anæmic areas over surface of liver; organ shows some furrowing on the surface; veins lying at bottom of these furrows.

No evidence of gummata.

Microscopic examination of liver tissue shows nothing special.

Spleen.—Large, rather soft, one accessory spleen size of a cherry.

Kidneys.—Large, moderately injected, typical cloudy swelling, but little opacity on M. E.

Intestines.—Show nothing special.

Stillate injection along rugæ of the stomach.

Thorax.—Universal adhesions of both sides.

Left lung.—650 grams, partly collapsed, on separation greatly injected; a few consolidated areas; bronchi much dilated, with thickened walls; foetid yellowish-brown contents.

At base some consolidation irregularly distributed, but always in the vicinity of the small pocket containing the grumous foetid material just mentioned. It is difficult to establish whether these pockets result from necrosis or bronchial dilatation.

Bronchial glands enlarged to size of walnuts, gray, succulent, soft and œdematous.

Right lung.—1820 grams, greatly enlarged, practically solid throughout, and very heavy; pleura adherent throughout; pleural surface studded with grayish yellow elevations resembling tubercles, but seem to be collections of yellowish pasty matter in minute cavities. Similar pockets filled with pasty matter are distributed through the lung, involving greater portion of the tissue. On washing the surface these stand out as small rounded sacs with shaggy inner walls, not showing granulation tissue or lining membrane, though often surrounded by firm, indurated areas.

On microscopic examination these spaces show no signs of tubercles, and are lined by altered, and to a large extent, necrotic epithelial cells, which are large and loaded with fat granules, and have a somewhat villous arrangement like hypertrophic epithelium in bronchiectatic cavities. The interior of the cavities consists almost entirely of cells; shows little or no elastic tissue. The intervening space between

the small cavities shows extreme consolidation, with thickening of the walls of the alveoli and some fibroid change. Contents of cavities show no tubercle bacilli.

Trachea and bronchi show a rough, reddened, thick mucosa.

Larynx at posterior angle shows two round ulcers with undermined areas. No sign of tubercle.

Bronchial glands unite, and form a mass as large as an apple, almost diffuent in places.

Microscopic examination of glands shows no cells except various leucocyte forms.

Heart—Valves reddened; coronaries free; substance healthy.

Brain—Vessels filled. Otherwise nothing special.

Testes, nothing special.

The course of the disease was thus a chronic bronchitis and bronchiectasis, terminating in fœtid bronchitis and septic pneumonia. The relation of the onset of the disease to whooping-cough and measles could not be determined, as the patient was unable to fix the dates at which he suffered from these maladies.

The clinical resemblance to tubercular pneumonia was very close; the sweating, remitting temperature and prostration, the extensive spreading consolidation of the lungs, the ulceration of the vocal cords, are all features which are familiar in such a condition. The result of systematic examination of the sputum was, however strongly against such a conclusion and pointed to a non-tubercular consolidation.

