

SUMMARY

1. Diamox does not appear to be toxic at daily doses of from 250 to 1,000 mgm.
2. It can be given for months at daily doses of 250 mgm. b.i.d.
3. Side-effects are minor.
4. The higher the ophthalmotonus, the more marked is the effect of the drug.
5. In acute cases, tension is lowered in the first 24 hours, but shows a tendency to rise, in spite of Diamox, and this in the few days following the first treatment (Fig. 1).
6. In acute secondary glaucoma there is also prompt improvement, and Diamox appears to improve the action of other drugs, especially in cases of iritis and iridocyclitis (Fig. 1).
7. In chronic glaucoma and normal eyes, lowering of tension is transitory and does not go below 14 mm. Hg with usual dosage (Fig. 1).

CONCLUSION

Acute glaucoma is the major indication for Diamox. In primary cases it gives better conditions for operation. In secondary cases due to iridocyclitis, it appears to relieve inflammatory reaction and thus ensures prompt improvement.

Our thanks are due to Lederle Laboratories Division, American Cyanamid Company, for providing us with the drug for clinical use.

INTRADERMAL HISTOPLASMIN REACTORS AT THE UNIVERSITY OF TORONTO

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IN A FORMER ARTICLE¹ the incidence of histoplasmin and tuberculin reactors was reported among University of Toronto students who had shadows indicating calcifications in a routine chest radiograph made by the Gage Institute for the University Health Service. Of 63 male students having calcifications, 36 reacted to histoplasmin, 33 to 1 mgm. or less of old tuberculin.

Since then we have encountered four students who, in routine radiographs, have presented definite abnormal parenchymal shadows other than calcifications, and in whom tuberculin tests were negative to 1 mgm. and histoplasmin intradermal tests were positive. Three of these lesions started to calcify under observation; one cleared slowly and completely in three months.

The occurrence of these four cases made us wonder what the incidence might be of positive

histoplasmin reactions among students here who showed no abnormal shadows in the radiograph.

Accordingly, first-year medical students were given intradermal tuberculin and histoplasmin skin tests by Dr. M. H. Brown of the Connaught Laboratories and Department of Hygiene of the University of Toronto. One hundred and forty-four were tuberculin tested, using 1/20 mgm. of O.T. and 1 mgm. when the first dose was negative. Of these, 66 were negative to 1 mgm., 64 were positive to 1 mgm. or less, and 14 were doubtful reactors to one strength or the other.

One hundred and thirty-five of the above group also received histoplasmin supplied by the Department of Health, Education and Welfare, Public Health Service, Washington, D.C. The results of the testing were as follows:

	H. positive	H. negative	Total cases
Neg. 1 mgm. O.T.	7	56	63
Pos. 1 mgm. O.T.	2	37	39
Pos. 1/20 mgm. O.T.	3	19	22
Doubtful 1 mgm. O.T.	2	7	9
Doubtful 1/20 mgm. O.T.	0	2	2
	14	121	135

Routine radiographs of the chest were made in all this group of 144 cases and only one case was found to show calcifications. This man reacted to histoplasmin and not to tuberculin.

Of the 134 cases showing no calcification in chest radiographs and tested with histoplasmin, 13 reacted to histoplasmin, an incidence of 9.7%. This is to be compared with an incidence of 57.1% of histoplasmin reactors among students showing calcifications in chest radiographs.

Where an abnormal shadow other than calcification is seen in a routine chest radiograph, and histoplasmin reaction is positive, this incidence of positive histoplasmin reaction in the presence of a normal film is to be recalled.

The positive reaction to histoplasmin does not mean that the infiltrate seen is necessarily due to histoplasmosis. Some further help in diagnosis is afforded by the course of the illness. Frequently calcification follows a histoplasma infection within one year, whereas a shadow due to virus pneumonia will clear quite rapidly.

CONCLUSION

The incidence of positive histoplasmin reactors was 9.7% in a group of 134 students at the University of Toronto who showed no calcifications or other abnormal shadows in a routine chest radiograph. In the Toronto region this figure is to be kept in mind when histoplasmin is used in the differential diagnosis of pulmonary infiltrates seen in x-ray films.

REFERENCE

1. HEATON, T. G.: *Canad. M. A. J.*, 62: 252, 1950.