

The diagnosis then, based on clinical, radiological, lipiodol, and bronchoscopic investigations, is one of generalized chronic bronchiolectasis with bronchiectasis at the left base.

(I am indebted to Dr. Stanley Melville and Mr. Ormerod for their help in connection with this case.)

Discussion.—Dr. WALTER CARR said that, if the history was correct, the changes in the lungs were probably due to a severe attack of measles, or whooping-cough, or both, in a possibly rachitic or delicate child, giving rise to a bronchopneumonia, which, as not uncommonly happened in such cases, became chronic and, by setting up fibrotic changes, led to the well-marked bronchiectasis at the left base and to much slighter changes at the right base. There might also be a little generalized fibrosis in the rest of the lungs, leading to some degree of bronchiolectasis.

Dr. H. V. MORLOCK said that he considered the bronchiectasis at the left lower lobe to be of congenital origin, because the definite cystic appearance of the lesion as shown in the straight skiagram as well as in the lipiodol film was the type of lesion seen in congenital cases, and not seen in bronchiectasis following a definitely known inflammatory lesion.

By inducing an artificial pneumothorax and then inserting a thoracoscope, it would be possible to gain more evidence in favour of the contention that the lesion was congenital.

It was just as logical to argue that the attack of measles had been the beginning of the infection in a dry congenital bronchiectasis, as it was to maintain that it was the cause of the bronchiectasis. With regard to generalized bronchiolectasis Dr. Ellman had produced no evidence at all to support this diagnosis except a skiagram which could equally well be interpreted as showing a simple fibrosis.

Dr. PHILIP ELLMAN said that bronchiolectasis had been described in 1891 by W. J. Carr¹ and his paper was worthy of careful perusal. He certainly could not agree that such a radiographic picture, the interpretation of which was detailed above—and was the considered opinion of no less an authority than Dr. Stanley Melville—could be obtained in simple fibrosis. The condition was, however, compatible with bronchiolectasis associated with fibrosis, as Dr. Carr had pointed out. He hoped at some future meeting to show the lungs, following autopsy, which would of course give even more convincing proof of this rare condition, about which one could not be absolutely dogmatic.

Dr. Stanley Melville considered that many of the dilated bronchioles were filled with secretion, giving the appearances of arteries cut across, in fact a miliary appearance not unlike that of miliary tuberculosis—which, however, can definitely be dismissed in this case. On the whole, he agreed with Dr. Morlock that, despite the onset of trouble occurring after whooping-cough at the age of 4, the bronchiectasis was most likely congenital in origin.

Rheumatic Fever following Erysipelas.—BERNARD SCHLESINGER, M.D.

J. A., a girl aged 8.

History.—1928, June. First attack of *chorea*. Previously well. The *chorea* cleared up without involvement of heart.

1929, December. Erysipelas of face, followed seventeen days later by severe attack of rheumatic fever with arthritis.

1933, April. Aged 13. Epistaxis and tonsillitis; heart disease first discovered.

November. Signs of early aortic regurgitation. Temperature, pulse-rate and sedimentation rate normal; gaining weight. Rheumatic process probably quiescent.

Carcinoma of Bronchus, as seen in serial Skiagrams.—C. E. NEWMAN, M.D.

D. Q., male, aged 58.

History of pain under the right clavicle and hæmoptysis since January 1933.

February.—Diminished movement, resonance and vocal fremitus, with distant bronchial breathing at right apex. X-ray appearance of post-previous fibrosis.

April.—Skiagram similar, but with more pulling over of the mediastinum.

May.—Bronchoscopy by Mr. Negus: White nodules of growth in right bronchus. Apex re-expanded after bronchoscopy and became clinically normal.

June.—Bronchoscopy: Similar appearance.

¹ W. J. Carr, *Practitioner*, 1891, xlvii, 87.