Three Cases of Pneumoconiosis.
ALAN WATSON.

These films (Figures 3, 4 and 5) show the occurrence of pneumoconiosis in merchant seamen, whose only exposure to dust took place while they were working as firemen in coal-burning ships.

Figure 3. This man (36) had a long but rather vague history of stomach trouble, but said he felt quite well when he was examined. He had worked for eight years in coal-burning ships. His film is fairly typical of Stage 1 pneumoconiosis, with some inactive P.T. in the right upper zone and apex.

Figure 4. This man (47) had been in hospital about five months before this film was taken, for treatment for P.T. and a tuberculous ulcer on the right vocal cord. He had worked for 15 years in coal-burning ships.

His film shows the scattered nodulation and short lines of fibrosis characteristic of second stage pneumoconiosis, with patches of tuberculosis in the right apex and middle zone. The trachea is pulled over to the right by the fibrotic reaction to the tubercle at the right apex.

Figure 5. This fireman (40) had spent about 10 years in coal-burners. His film shows the more massive shadows associated with Stage 3 pneumoconiosis. At the time that it was taken he was symptomless, and after investigation in hospital he was reported to have pneumoconiosis and inactive tuberculosis. Six months later he developed chest symptoms and tubercle bacilli were found in his sputum.

If any of you know of any other cases of pneumoconiosis in seamen who have been exposed to coal-dust only in ships I shall be grateful if you will tell me about them; I have not been able to discover any myself.

A Case of Congenital Heart Disease
ALAN WATSON.

This patient (59) complained of bouts of pain in the chest for about a year. The pain came on with exertion, but he also got it in bed at
night, and it was never very severe. He also had some dyspnoea, and quite marked symptoms of anxiety and depression. He had had no serious illness apart from one attack of V.D. during the First World War, which he was certain was gonorrhoea.

In this L.A.O. view (Figure 6), after a barium swallow, you can see that there is something pushing the oesophagus forwards here—and on the screen I saw that the "something" was pulsating. In the P.A. view there is nothing very abnormal, but you can see that there is some rib-notching. He had harsh aortic and soft mitral murmurs—both systolic—and a variable diastolic one to the left of the sternum. His blood pressure was 180/90, and he had an easily felt tracheal tug. We felt pretty sure he had an aortic aneurysm.

He was seen by a cardiologist, who found negative W.R. and Kahn reactions, and who after studying these angiocardiographs reported that he had a left sided superior vena cava and a constriction in the third part of the aortic arch with a dilatation below it, or in other words a mild co-arctation. This is the cause of the forward bulge in the oesophagus in the first film I showed you, and of the rib-notching. Also, he possibly has a vascular ring around the oesophagus—you can see here what may be a vessel which is part of the ring. In this film you can see a very dilated left subclavian artery, which is adherent to the trachea, pulling it over to the left and causing the tug.

These are all congenital abnormalities of no serious import, and his pain was almost certainly psychogenic in origin. I think this case illustrates the importance of making an accurate diagnosis. If we had been satisfied with our own diagnosis of aneurysm this man would have lost his job, whereas he is now quite happily back at work. (Dr. Watson showed the angiocardiographs.)

Figure 5. Stage 3 pneumoconiosis with tuberculosis.

Figure 4. Stage 2 pneumoconiosis with patches of tuberculosis.

Figure 6. Barium swallow. Mild co-arctation of the aorta.