Computed tomographic scan of the chest from (A) 1991 showing a giant bulla in the right lung with significant shift of the mediastinum to the left and (B) in 1993 showing a dramatic reduction in the size of the bulla. Note that the lung is almost completely re-expanded and the mediastinal shift is resolved.

inflammation may further obstruct already compromised bronchial communications with the bullae resulting in a closed space. Eventually fluid and then air resorption leads to regression of the bulla. If this mechanism is valid, one might speculate that other known causes of airway obstruction such as tumour, mucous plugging, or blood clot could also lead to shrinkage of the bulla. A retrospective review from Japan reported three cases of lung bulla regression associated with bronchogenic cancer, although no details on individual cases were provided.10

Our case is of interest not only because of the rarity with which spontaneous regression has been reported in the literature, but also because it was associated with such dramatic improvements in the radiological picture and pulmonary function. Unlike earlier reports, this occurred in the absence of overt infection or tumour. Re-expansion of compressed lung and reversal of mediastinal shift was accompanied by improved pulmonary blood flow. Substantial increases in FEV₁ as documented in this patient, are sometimes seen following surgical bullectomy in well selected patients. Our patient was not thought to be a good candidate for bullectomy because of diffuse emphysema, which underlines the difficulty in selecting patients for surgery.

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Sternocostoclavicular hyperostosis presenting with thoracic sinus formation

G E Wilson, C C Evans

Abstract

Sternocostoclavicular hyperostosis (SCCH) is a condition which is well described in the Japanese literature but is rare in Western Europe. It is characterised by pain and swelling in the upper anterior part of the chest, which tends to be progressive. A patient is described with bilateral chronic discharging sinuses over the anterior ends of the clavicles in whom the diagnosis appeared to be one of SCCH.

(Thorax 1996;51:550–552)

Keywords: sternocostoclavicular hyperostosis, thoracic sinus, pustular psoriasis.

Case report

A 75 year old woman of Ashkenazi Jewish extraction was referred because of increasing shortness of breath. For five years she had suffered from recurrent clavicular problems. Initially this had been swelling, pain, and stiffness around the medial ends of the clavicles.

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Sternocostoclavicular hyperostosis presenting with thoracic sinus formation

Sternocostoclavicular hyperostosis (SCCH) is a condition with an equal sex distribution whose peak incidence occurs in middle age. The original reports were from Japan in 1967, although since then cases have been described in America and Europe (there does not appear to be an increased incidence in Japanese migrants to these areas). The disorder was first reported by Sasaki who described a case of bilateral hyperostosis of the clavicles associated with pustulosic palm and plantaris. No single aetiological agent has been defined and culture of bone biopsy specimens of resected material has failed to demonstrate an infective cause.  

Discussion

Stemocostoclavicular hyperostosis (SCCH) is a condition with an equal sex distribution whose peak incidence occurs in middle age. The original reports were from Japan in 1967, although since then cases have been described in America and Europe (there does not appear to be an increased incidence in Japanese migrants to these areas). The disorder was first reported by Sasaki who described a case of bilateral hyperostosis of the clavicles associated with pustulosic palm and plantaris. No single aetiological agent has been defined and culture of bone biopsy specimens of resected material has failed to demonstrate an infective cause.  

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There is debate over the pathogenesis of the disease. Kholer et al. proposed that it is an ossifying periostitis which begins within bone and progresses to a generalised hyperostosis, but Fritz et al. have argued that it is primarily a rheumatological rather than an orthopaedic condition. The diagnosis is primarily clinical and radiological. The most frequently abnormal laboratory investigations include increased ESR, C-reactive protein and alkaline phosphatase. Radionuclide studies show uptake in the sternoclavicular region and may show extranodal involvement.

Radiological features of SCCH are said to be characteristic and have been classified into three stages by Resnick. In the case described here the changes corresponded with stage II, with marked destruction of the sternoclavicular joints, the clavicle, and formation of an ossific mass. Extrinsic compression of the subclavian vein and brachial plexus neuropathies due to the effect of local pressure have been reported.
Lymphangitis carcinomatosa complicating primary malignant peritoneal mesothelioma

Paul S Craft, Martin S Reading, Sanjiv Jain, Ross A O'Neil

Abstract
A patient with malignant peritoneal mesothelioma and a diffuse pulmonary infiltrate is described. Computed tomographic scanning suggested lymphangitis carcinomatosa. This was confirmed on transbronchial biopsy to be due to metastatic mesothelioma.

Keywords: peritoneal mesothelioma, lymphangitis carcinomatosa, metastasis.

Malignant mesothelioma is a rare tumour with an annual incidence of between 0.7 and 1.5 per million.1 Increasing incidence has been reported in many countries including the United States and, in particular, Australia.1 The disease is strongly linked to asbestos exposure, particularly crocidolite. Approximately 10% of mesotheliomas arise from the peritoneum.4 Lymphangitis carcinomatosa is characterised histologically by diffuse permeation of tumour cells within pulmonary lymphatics. We are not aware of any previously reported examples of lymphangitis carcinomatosa due to malignant mesothelioma.

Case report
A 52 year old man presented with a two month history of weight loss and upper abdominal pain. There was a history of asbestos exposure 20 years earlier. A chest radiograph, taken at the onset of symptoms, was normal. An abdominal computed tomographic (CT) scan showed a diffuse omental mass. Needle biopsy yielded cytologically abnormal mesothelial cells consistent with mesothelioma.

One month later the patient developed a non-productive cough and exertional dyspnoea. Auscultation of the lung fields revealed bilateral fine basal crackles. The chest radiograph on this occasion showed a widespread reticulonodular pattern with septal thickening. A high resolution CT scan of the thorax revealed diffuse nodular thickening with polygon formation (fig 1). Bronchoscopic examination was normal. Transbronchial biopsy specimens showed abnormal epithelioid malignant cells with mild nuclear pleomorphism and prominent nucleoli. These cells were identical to those obtained from the previous omental needle biopsy. Ultrastructurally they showed long branching microvilli consistent with mesothelioma (fig 2). Cytotoxic chemotherapy with cisplatin and doxorubicin was associated with stable disease for three months. The patient died eight months after presentation from respiratory failure due to progressive disease.

Sternocostoclavicular hyperostosis presenting with thoracic sinus formation.

G. E. Wilson and C. C. Evans

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