surrounded the right kidney and the right ureter. The subcapsular surface of the kidney showed numerous small pinpoint scars, suggestive of arterial disease, but the parenchyma appeared normal. The adrenal glands were not involved in the hemorrhagic mass.

The principal autopsy diagnoses were: (1) Ruptured abdominal aortic aneurysm with retroperitoneal hemorrhage; (2) arteriosclerosis of the kidneys; (3) arteriosclerosis of the coronary arteries and aorta.

**SUMMARY**

In the case of ruptured aneurysm of the abdominal aorta here reported, the predominant symptom was pain in the right testicle. There was neither tender-

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**Adult Chickenpox Pneumonia**

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**Primary varicella pneumonia** in adults, previously reported as a rare disease, was recently shown to be not uncommon in a series of adult cases of chickenpox. The purpose of this report is to describe a case of adult varicella pneumonia, characterized by cyanosis and severe air hunger, and to indicate the importance of an x-ray film of the chest and careful thoracic examination in cases of chickenpox in adults.

**REPORT OF A CASE**

A 37-year-old white man was admitted to the 6510th USAF Hospital on May 27, 1958, because of severe shortness of breath. Two weeks before admission his 8-year-old child had had varicella, a disease the patient had not had as a child. He had had small-pox vaccination in 1957. Three days before admission a rash developed on the patient’s forehead, face and trunk, then spread to his legs. Two days before admission he noted shortness of breath and cough productive of thin white sputum with occasional flecks of blood. Coughing grew constant, and shortness of breath became so severe that he presented himself to the hospital emergency room.

When examined, the patient, who was tall and well developed, was breathing shallowly and rapidly. The skin, nail beds and mucous membranes were cyanotic. A generalized eruption of mixed papules, vesicles and crusts typical of varicella was present. On the hard palate there was a small white vesicle. The entire lung fields were dull to percussion. Tactile and vocal fremitus were everywhere diminished, and medium moist, inspiratory and expiratory rales in the abdomen and flanks nor a palpable mass in the abdomen. Not until the patient went into shock was the true diagnosis suspected.

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**REFERENCES**

chest showed a confluent nodular infiltrate through- 
out both lung fields.

The patient was placed in an oxygen tent in or- 
thopneic position and treated with penicillin and 
streptomycin until the reports of no growth of blood 
and sputum cultures were received. Tachypnea and 
cyanosis steadily decreased and supplementary oxy-
gen was discontinued eight days after admission. 
Serial x-ray films indicated a change from a nodular 
to a linear lung infiltrate. He was discharged June 
23, 1958, and remained well, with no abnormalities 
in x-ray films of the chest.

DISCUSSION

Forty-five cases of adult varicella had been re-
ported in the literature previous to the present case. 
Although the pneumonia complicating childhood 
chickenpox is generally bacterial, it is almost always 
viral when it occurs in adults. Postmortem exami-
nations of adults who died of chickenpox have revealed 
typical pathological lesions of chickenpox in the 
lungs. Dyspnea and cyanosis result from gross in-
volve ment of lung tissue and interference in oxygen 
exchange because of cellular debris present in the 
alveoli. On x-ray films the infiltrate often appears 
confluent and nodular.

Once proper studies have been performed to rule 
out bacterial cause of the pneumonia, symptomatic 
care with oxygen and maintenance of orthopneic 
position should be given. Antibiotics are futile.

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The Familial Occurrence of Chronic 
Lymphocytic Leukemia and Multiple 
Myeloma

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The report herewith is of the occurrence of chronic 
lymphocytic leukemia in a mother and multiple mye-
lo ma in one of her two sons. We have not been able 
to find a previous report of the presence of these two 
hematologic malignant diseases in the same family.

Case I. The patient, an 84-year-old white woman, 
was first observed at the Los Angeles County Gen-
eral Hospital in 1955 because of vague, generalized 
pain which had been present for many years. A diag-
nosis of chronic lymphocytic leukemia had been 
established by lymph node biopsy at another hospital 
in 1942. At that time leukocytes numbered 22,000 
per cu. mm., 76 per cent lymphocytes. The diagnosis 
had been confirmed in 1950 by bone marrow exami-
nation and liver biopsy at the same hospital. Examina-
tion of the blood in 1953 showed 80,000 leuko-
cytes per cu. mm., 95 per cent lymphocytes.

Upon physical examination in 1955 the patient 
was observed to be well developed and well nour-
ished. Moderate cardiomegaly and auricular fibrilla-
tion were present. The edge of the liver was palpated 
one or two finger breadths below the right costal 
margin and the spleen to two finger breadths 
below the left costal margin. There was no enlarge-
ment of peripheral lymph nodes. The hemoglobin 
content was 12 gm. per 100 cc. of blood and leuko-
cytes numbered 48,400 per cu. mm., 90 per cent of 
them mature lymphocytes.

Between 1955 and 1959 the patient was observed 
from time to time in the outpatient medical clinic 
with occasional admission to the hospital for man-
agement of heart disease. The liver and spleen shrank 
during that time and were no longer palpable. Enlarged peripheral lymph nodes were never 
felt. The hemoglobin content varied between 10 and 
12 gm. per 100 cc. and the number of leukocytes be-
tween 60,000 and 100,000 per cu. mm.

In March, 1959, the hemoglobin fell to 7.0 gm. per 
100 cc. and the number of leukocytes rose to 118,000 
per cu. mm. Two units of whole blood were given 
but the patient died about three weeks later. Autopsy 
was not done.

It is noteworthy that this patient did not receive 
specific antileukemic therapy at any time during the 
17 years she was known to have lymphocytic leu-
kemia.

Case 2. The 51-year-old son of the patient in Case 
1 entered Los Angeles County General Hospital in 
December, 1958, because of skeletal pain associated 
with osteolytic lesions demonstrated on roentgeno-
grams taken by a physician he had consulted. The 
only abnormality noted on physical examination was 
tenderness over the thoracic and lumbar vertebrae 
and over the upper extremities. The hemoglobin 
content was 14.0 gm. per 100 cc. of blood and leuko-
cytes numbered 8,400 per cu. mm. with a differential 
count on stained smear within normal limits. Uri-
alysis revealed 4+ proteinuria and Bence-Jones 
protein. The serum protein contents were within 
normal range. Roentgenograms showed multiple 
osteolytic lesions of the clavicular, humeri, radii,