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Pulmonary geotrichosis

Sir,

Saprophytic fungi are known to produce opportunistic infections in immuno-suppressed individuals. Geotrichosis is a mycotic infection with oral, intestinal, bronchial or pulmonary lesions, caused by the ubiquitous fungus *Geotrichum candidum*.¹ Pulmonary involvement simulating tuberculosis is frequently reported.² A case of geotrichosis in an old tuberculous lung cavity occurring in an immunocompetent individual is reported.

A 45 year old male presented with cough and streaky haemoptysis of one week duration. He had been treated six years previously for pulmonary tuberculosis for a year. Examination revealed an ill looking male with extensive physical signs in the right chest. Chest X-ray showed a fibrocavitary lesion in the right upper zone and apicogram revealed a large cavity containing a solid density mass in the right upper lobe.

Geotrichum candidum was isolated in all 10 freshly expectorated sputum specimens. The particular features of *G. candidum* were absence of urea utilization, assimilation of glucose and galactose but not maltose, sucrose, salicin, inositol or raffinose, thus differentiating from genus *Trichosporon*. The patient responded to oral administration of a supersaturated solution of potassium iodide for 3 months.

Geotrichum candidum, which belongs to the class Fungi imperfecti, is an opportunistic human pathogen.¹ The repeated isolation of *G. candidum* with characteristic arthrospores and hyphae in freshly expectorated sputum samples and the absence of other pathogenic fungi or bacilli either by direct microscopy or culture of sputum confirms the diagnosis of geotrichosis.^{2,3} Radiologically, there may be patchy or fluffy infiltrates with a predilection for the upper lobes and, occasionally, cavity lesions (as in our patient). Although use of neomycin and colistin is anecdotal, nystatin and iodide preparations have been used commonly.^{3,4} Miconazole, clotrimazole, amphotericin B and 5-fluorocytosine have been shown to have *in vitro* activity at attainable concentrations.⁴

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Urinary bladder carcinoma initially manifested as brain metastases

Sir,

Only 1% of transitional cell carcinomas (TCC) of the bladder give rise to brain metastasis throughout their natural history.^{1,2} Similarly, a bladder origin has been discovered in only approximately 1% of patients with cerebral metastases.³ We describe two cases of bladder carcinoma, the clinical presentation of which was solely due to the presence of brain metastases.

Case 1

A 67 year old male developed complete homonymous hemianopia, visual agnosia and a brief history of disorientation. Physical examination showed left supraclavicular adenopathy and tomographic (CT) scan confirmed a left occipital mass. Gland biopsy showed undifferentiated carcinoma. Further investigations revealed infiltrating bladder cancer with local and distant lymphadenopathy. There were no previous urological symptoms and haematuria only developed later. Autopsy gave histological confirmation for both TCC of the bladder and cerebral metastases.

Case 2

A 54 year old male, with a perineal urethral orifice following urethroplasty, complained of multiple urinary stones and urinary tract infection. He complained of frequent bifrontal headaches that awoke him during the night, and emotional lability and undue irritability. Generalized seizures and weakness of his left arm developed. Papilloedema was discovered and a small right periventricular mass that enhanced with contrast