though that inherently the situation is the same here as with the neurotic individual. For in whatsoever way it is sought to soften the stern aspect of reality, whether through the artificial appeasements and irrationalities of the social polity, with its phantastic mythological beliefs and superstitions, or through the yet subtler assuagements of the neurotic personality with his vicarious conversions and distortions, back of it all and actuating it all is, as I have said, an inveterate and inherent egotism.

I have said that egotism is the more comforting course. If we would judge how much more comforting is the course of egotism, we need only reflect on the part it plays in the complex of activities which we call life. Consider for a moment to what extent the criteria by which we live are colored by egotism. Consider the part that egotism plays in our restless social, commercial and political activities. Consider to what extent the aspiration which we call religion is imbued with the egoistic hope of ultimate rewards and satisfactions.

And more tragic still, consider how often the activities we call scientific — that is, the supposedly sincere inquiry into truth — are actuated by an egotistic spirit of pride and self-assertion. Think how even here this organic and inveterate pleasure-principle asserts itself in human affairs to the detriment or undoing of honest purpose!

When we regard the deeper, more biologic aspects of human life — the interests and demands which arise from the sphere of the sex instincts and emotions — we find that here egotism is at its source, for it is one with the primary pleasure-affects in which the impulse of sex has its genesis.

Egotism is precisely the enemy of human progress against which the psychanalyst levels his aim. Under whatsoever sham egotism thinks itself most safely concealed, it is here that the psychanalyst directs his attack.

The task of the psychanalyst, therefore, is the readjustment of the neurotic patient through a process of self-elimination. It is his task to replace caprice with logic, emotion with reason, temporary satisfaction with permanent truth. The psychanalyst then takes his stand on adult characterologic ground. He recognizes that the abnegation of immediate selfhood is the highest attainment within the ethical nature of man, that the subversion of the primary, infantile pleasure-mode is the supreme renunciation.

We contend that since a great part of the beliefs and customs of the community have at heart the same underlying motive as actuates the symptoms of the neurotic patient with his organic evasions and substitutions, namely, an inherent egotism, the trend of the psychanalyst not only aids, in its reeducative influence, the individual, but also makes for a better and a healthier community. For the psychanalyst would utilize this force resident in the onward effort of mental evolution. He would direct to better uses this impulse of self-attainment which lies at the source of the manifestations which we call life, for with the attainment of consciousness the possibility is opened for converting this genetic life-force into a constructive and a purposive principle. With the gradual enlarging of consciousness it has become more and more adapted to social and ethical ends. Thus through the sublimating process of mental growth, egotism becomes diverted into self-devotion.

Life is wrought of aspiration; conduct is begotten of desire. Back of the restless energies of men there is this elemental instinct of attainment which constitutes the driving force of humanity itself—"humanity old, untruthful, deluded, wandering among a thousand cheats, clinging to outworn customs and beliefs, pretending to nobilities not its own, lending itself here, there, everywhere among a thousand falsehoods; humanity with its ineffectual virtues, its imperfect vision;" and yet for all its frailty and folly, for all its silly self-delusion and pitiful egotism, the deeper the psychanalyst applies himself to the study of human motives and to the interpretation of human life, the more clearly he discerns within this same humanity the deeper forces, making for order and continuity, which lie at the heart of life's processes.

The psychanalyst, therefore, who rightly appraises his work cannot but be deeply sensible of the honesty and the dignity of his endeavor, and of its wide social usefulness, for his efforts are allied with the forward progress of the race.

707 St. Paul Street.

ANEURYSM OF THE SINUS OF VALSALVA

WITH REPORT OF TWO CASES

W. ATMAR SMITH, M.D.
CHARLESTON, S. C.

Although a search through the literature does not seem to substantiate the fact that aneurysm in this situation is common, it undoubtedly impresses one that the lesion is sufficiently frequent for the clinician to keep in mind.

FREQUENCY

The frequency of this aneurysm is difficult to compute accurately. Among the "special features" pointed out by Osler[1] are the statements: "It is often latent, causing sudden death by rupture into the pericardium. It is a medicolegal aneurysm met with in coroners' cases." Possibly because of this a large percentage of cases do not get into the records.

Cattell and Steele,[2] in reporting a case of aneurysm of the sinus of Valsalva, state that it is a very rare pathologic lesion, their case being the first in 2,000 necropsies. In 3,108 necropsies Bosdorff reports two. In the Middlesex Hospital Reports, containing protocols of 3,030 cases, there were two of aneurysm in this situation. Thus in 8,138 post-mortems only seven were found.

In 1840 Thurman collected twenty-two aneurysms affecting the aortic sinuses. In 1874 Durand reported twenty-two. Cattell and Steele, from whose monograph many of these data were obtained, collected twenty-one reports of cases up to 1898. I have found in the literature but seventeen cases between 1840 and 1903. It is impossible, too, to be sure whether or not some of them were not included by the authors mentioned above.

Sibbs collected 632 reports of cases of aneurysm of the arch, eighty-seven of which involved the sinuses of Valsalva. This was quite the largest percentage of occurrences found and is not generally borne out by other observers. In 120 cases of aneurysm of the

1. Osler: System of Medicine, Ed. 8, p. 851.
2. Cattell and Steele: Tr. Philadelphia Path. Soc., 1898.

arch reviewed by Cattell and Steele, only seven were found in this situation.

Recent literature on the subject is very meager. There is a record of but three cases between 1905 and 1912.

These data would tend to confirm the view of the infrequency of this lesion, but it is entirely possible that the record, although the best we have, is not a true index of its real occurrence.

The sinus most often affected seems to be the right anterior; this is explained by Gray by the fact that the regurgitation of the blood takes place chiefly against the anterior aspects of the vessel.

Sinusal aneurysm may terminate in one of several ways. It may rupture into the pericardium. It may rupture into one or more of the cavities of the heart, the vena cava or the pulmonary artery. Of the twenty reports of cases collected by me, in two the aneurysm perforated the right auricle, in one the left ventricle and pulmonary artry, in one the pericardium and in five the pulmonary artery.

It has been stated that rupture does not lead to immediately fatal results, but death occurs most often from fatty degeneration of the hypertrophied myocardium. The aneurysm not rarely causes a relative dilatation of the aortic ring and leads to death from cardiac failure.

ETIOLOGY

The lesion occurs according to most authorities in young adults; as Osler puts it, "most frequently among young syphilitics." Of my cases, in only eleven were ages stated; four were in the third decade, four in the fourth, one in the fifth and two in the sixth. The lesion predominates in the male. In only one case in the literature could I find a woman affected. This is rather striking in view of the fact that the two cases, a report of which follows, were in young women.

Krzywicki states that the causes of aneurysm of the Valsalvian sinus are atheroma, increased pressure affecting points of least resistance, and syphilis. Roubier and Bouget concur, but they are "certain that syphilitic aortitis presides in these ectasias." "Peacock thought that certain of these aneurysms were due to congenital malformations which observations by Devic and Savy seem to confirm."

The majority of observers, however, recognize syphilis as the most potent etiologic factor.

REPORT OF CASES

Before considering the symptoms and signs of this lesion, I would first report the two cases coming under my observation, as they illustrate fairly well the usual manifestation of this condition.

Both of these cases occurred at the Roper Hospital under the service of Dr. Robert Wilson, Jr. Both patients were young negresses, aged 17 and 26, respectively, and both showed evidences of syphilis. The cause of death in both instances was venous stasis. In the first case there was dilatation of the aortic ring; in the second, perforation into the pulmonary artery. These cases, added to those previously collected, make twenty-two in all, six of which perforated the pulmonary artery.

CASE 1.—L. W., colored girl, aged 17, was admitted to hospital, Oct. 24, 1913, complaining of cough which began in the previous summer and persisted to the present; shortness of breath, weakness, pain under left nipple and edema of feet and legs. Latter symptoms began two weeks before and grew progressively worse up to the time of entrance. Past history negative. Physical examination revealed scars over tibiae, swelling of feet and legs, hurried and difficult respiration, rapid irregular pulse, wavy pulsations over precordium, especially at base. Thrill at base was most distinct over second and third intercostal spaces on the left of the sternum. It was impossible to decide whether this thrill occurred during systole or diastole, but it probably occurred during both. Apex was displaced downward and to the left. Cardiac dulness was increased to right and left of sternum. A loud humming "saw-like" murmur was heard over precordium, but with greatest intensity in third left interspace about 2 inches from sternum. In this location the bruit was extremely loud, of a high pitched rasping quality, and distinctly to-and-fro in character. At this site could also be heard a rather sharp snap, resembling a very accentuated closure sound. Because of the irregular heart-action and the peculiar murmur, it was impossible to determine during what part of the cardiac cycle it occurred. Roentgenoscopy revealed a great hypertrophy of both chambers, especially of the right ventricle.

The patient died November 19, with gradual rupture of compensation.

Necropsy.—General anasarca. Ascites, 750 c.c. Right pleural effusion, 500 c.c. Hydropericardium, 200 c.c. Chronic mitral valvulitis with dilatation of orifice and insufficiency. Dilatation of tricuspid orifice. Chronic aortic valvulitis with contraction of leaflets, dilatation of orifice and insufficiency. Sclerosis and atheroma of aorta with dilatation of atheromatous patch in right sinus of Valsalva, producing a saccular aneurysm of the sinus large enough to admit the end of the thumb and causing further dilatation of the aortic ring. General cardiac hypertrophy with chronic interstitial myocarditis, sclerosis of coronaries, parenchymatous and fatty degeneration of myocardium with general dilatation. Chronic passive congestion in other parenchymatous organs.

CASE 2.—B. L., colored woman, aged 26, was admitted to hospital, Feb. 27, 1914. Hysterectomy had been performed one year ago. Since then patient has been well except for occasional headache and feeling of dizziness, until Jan. 1, 1914, when symptoms of present trouble appeared. These consisted of cough, feeling of fulness in chest, dyspnea and edema of ascending type. The physical findings in this case were very similar to those in the preceding one. There was a greater degree of respiratory distress, more marked edema and the pulse was regular, but the most important difference was the absence of the loud closure sound which was so well marked in Case 1.

Roentgenoscopy revealed a large heart with pronounced distention of the right side.

Necropsy.—General anasarca. Papular eruption on forehead. Scars of old ulcer on right leg. Operative cicatrix in midline of abdomen. Excess of pericardial fluid. Mitral valves thickened but sufficient; atheroma and sclerosis of aorta with dilatation of atheromatous patch in right sinus of Valsalva producing aneurysm which projects through septum into pulmonary artery, perforating by two small openings behind the corresponding pulmonary valve. The sac admits the index-finger. General dilatation and hypertrophy of heart with fatty and parenchymatous degeneration of the myocardium.

DISCUSSION

It is not always possible to explain physical signs from the point of view of pathology, but we should try to do so, that our observations may be of value in future experiences. In the first case the striking signs were the loud to-and-fro "saw-like" murmur and thrill, the cardiac hypertrophy, especially of the right ventricle, the precordial pulsations and the so-called "closure" sound. There were probably several conditions responsible for the murmur, for, besides the aneurysm, there was an aortic insufficiency and a valvulitis of the mitral orifice causing insufficiency there. The cause of the cardiac hypertrophy is therefore

obvious. The closure sound was probably diastolic and due to congestion in the lesser circulation.

The murmur in Case 2, in which there was perforation, can be accounted for by the to-and-fro passage of blood during the two phases of the cardiac cycle from aorta to pulmonary artery. It is easily conceivable that the churning of the blood caused thereby would produce the thrill. The hypertrophy of the right ventricle was caused by the increased quantity of blood in the pulmonary circulation due to the leak from the aorta.

The majority of other symptoms exhibited by these patients were simply those of failing compensation. It should be recalled that death in both cases was due to the effects of the aneurysm, namely, myocardial degeneration, and not to rupture.

DIAGNOSIS

In neither case cited was the diagnosis made ante mortem. In the first the youth of the patient, the peculiar murmur, the pulsations and thrill, with the valve-sound heard loudest over the pulmonary area and the right ventricular hypertrophy shown by the Roentgen ray were strongly suggestive of patulous duct of Botalli. In fact, we did not feel that this condition could be thrown out in spite of its rarity. We felt reasonably certain that mitral stenosis was present even if there was no persistent ductus to account for part of the signs. This proved incorrect.

In the perforating case we felt that here too there was a strong possibility of mitral stenosis playing a part in the findings. This was suggested by the hypertrophied right ventricle. Aneurysm of the heart wall was considered by one of the observers because of the precordial pulsations, the thrill and murmur.

It will readily be seen that the diagnosis of aneurysm of the sinus of Valsalva, perforating or otherwise, presents almost insurmountable difficulties. In fact, I have found no case on record in which it was stated that the correct conclusion was reached ante mortem. W. F. Wade in 1861 reported a case of aneurysm of the aorta arising above the valves and perforating the pulmonary artery and right ventricle in which the diagnosis was made before death. This is the nearest approach to the condition rightly interpreted.

There are no signs particularly peculiar to the lesion. The aneurysm may remain latent until rupture. In a case reported by Ralfe the signs were increased precordial dulness, double bruit at base and a faint systolic murmur at the apex. In a case by Stokes in which the sac ruptured into the conus arteriosus of the pulmonary artery, there was a thrill over the sternum and a double murmur heard best over the left base, but heard all over the chest even by the patient himself. In F. P. Henry's case, in which the aneurysm also opened into the pulmonary artery, the signs were dulness in left infraclavicular region, pulsation and thrill in the second left interspace, and a rasping systolic murmur over the same area. These findings and the findings in the two cases observed by me, although varying in many respects, are fairly constant in one particular: nearly all signs are referable to the pulmonary area or, rather, they are more marked in that situation.

In none of the cases contained in the literature was the Roentgen ray used as an aid to the diagnosis of this condition. This is important, as by means of roentgenoscopy any ectasias of the arch which might give identical signs could be discerned.

In conclusion it might be stated that aneurysm of the sinus of Valsalva, although comparatively uncommon, is not so rare as to be altogether devoid of clinical interest, and, although the diagnosis is infrequently justified, the lesion cannot be excluded in the face of the finding, in a young syphilitic, of a saw-like bruit and thrill most marked in the pulmonary area and a negative roentgenogram.

THE TREATMENT OF GALL-BLADDER INFECTIONS

WITH A REPORT OF TWENTY-SIX RECENT CASES *

JOHN H. GIBBON, M.D.
PHILADELPHIA

Although asked to discuss the "treatment of gall-stones," I have preferred to substitute the word "infections" for "gall-stones," as we now know that the primary cause of these stones is a microbic infection reaching the gall-bladder either through the blood or directly through the bile-passages from the intestine.

It is not my intention to deal minutely with the various operations which may be required in gall-bladder diseases, but rather to consider the indications for operative interference in these diseases and to present some of the pathologic complications which may arise when these indications are not heeded. I shall also say something about the mortality following operative treatment and its causes.

As a basis for my remarks I have taken the gall-bladder cases in which I have operated during the past six months and shall give a brief synopsis of each case. They number twenty-six, fourteen patients having been operated on at the Jefferson Hospital and twelve at the Pennsylvania Hospital. My figures might be more convincing if they were larger, but they represent a season's work and sufficiently illustrate every point I would like to make.

In considering the indications for operation, I would say that if one feels warranted in making a diagnosis of gall-stones or gall-bladder infection, he should also feel warranted in advising operation, unless there be some definite contra-indication. I am sure we all agree that if stones are present, no medicinal agent can dissolve them or make them pass through the ducts into the intestine. If the passage of stones does occur, it is Nature and not medicine that brings it about, and the passage of a few or many stones does not mean that all have passed or will pass. Case 12 illustrates this point well. While we are waiting and watching for our medicines to do the impossible, or while we are helping our patients to bear the repeated attacks of colic, the stones are increasing in number and in size, and the patient is running the risk of developing one of the serious complications to which gall-stones give rise and which are amply illustrated in the accompanying cases. When the stones are in the gall-bladder only and the drainage of that organ is not disturbed, an operation is a simple matter; but when

* Because of lack of space, this article is here abbreviated by omission of the case-reports. These, however, will appear in the author's reprints, a copy of which will be sent by the author on receipt of a stamped, addressed envelope.