Clinical Notes:

MEDICAL, SURGICAL, OBSTETRICAL, AND THERAPEUTICAL.

A CASE OF ANEURYSM OF THE DESCENDING THORACIC AORTA PRESENTING SOME UNUSUAL FEATURES.

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THE points of interest in this case appear to be: (1) The absence of manifest physical signs during a long course of severe symptoms (it was only in the last few weeks of life that a diagnosis was established); and (2) the unusual direction that the aneurysmal sac took—into the base of the *right* chest.

The patient, a male aged 43 years, was first admitted to Lambeth Infirmary in July, 1911, complaining of periodic attacks of pain resembling right renal colic. There was a history of similar attacks for two years previously. Physical examination and examination of the urine were negative. He remained in the infirmary a week, and went out "improved"; but the nature of his pains was undetermined.

The patient returned to the infirmary on Jan. 31st, 1912, and remained until Feb. 15th. He had several attacks of apparently agonising pain radiating from the right hypochondrium to the right groin while in the infirmary, but again a careful examination of chest, abdomen, and urine failed to throw light on the condition. There were no signs of locomotor ataxy, and no history of syphilis was elicited.

On May 21st the patient came to the infirmary again, and remained until July 18th. His symptoms were as before, but his general appearance had deteriorated. His skin was getting pigmented, almost suggesting Addison's disease. It was now noticed that the apex beat of the heart was a little outside the usual position, and there was a heaving impulse around the nipple. A faint systolic mitral bruit was heard.

On July 23rd the patient was again admitted to the infirmary with similar symptoms and he remained until August 29th. On admission it was noticed that his right kidney appeared palpable. The urine was normal. On July 25th he developed signs and symptoms of right basal pleurisy with some blood-stained expectoration. It was noticed that he was getting sallower, with general loss of muscular tone. The systolic blood pressure on July 27th was 130 mm. Hg. The symptoms improved and the patient was discharged on August 29th, but with some dulness at the right base.

The patient was finally admitted on Nov. 7th, 1912. His general condition appeared worse. He was sallow, flabby, and rather wasted. There was still some dulness, with deficient breath sound at the right base, and the heart apex beat was outside the normal position, but otherwise nothing was made out to account for the severe pains that he still suffered periodically. I heard that he had been in Middlesex Hospital in the March previous, and Dr. K. D. Marriner, the medical registrar, kindly informed me that a positive Wassermann reaction had been given, and that the case had been treated for specific myocarditis. The patient continued to suffer great pain in the loin, but no change was observed in the physical signs until December, when a heaving pulsation was noticed at the right base. It was obviously an aneurysm, either of the aorta or of the right renal artery. No pulsation was felt in the abdomen.

Laparotomy was performed on Dec. 17th by Mr. Wilfred Trotter, and the condition was found to be an aneurysm of the thoracic aorta bulging the diaphragm downwards and extending behind the liver. The aneurysm increased rapidly in size and formed a striking pulsating swelling in the right base. The patient became gradually weaker and died on Jan. 10th, 1913.

Post mortem a limited examination was made. The heart was apparently healthy, not enlarged, but displaced. The right pleural cavity contained much clear sero-sanguineous fluid, and there were extensive fine adhesions between the right lung and the pleura. The whole extent of the aorta showed diseased intima, which was extensively marked with brittle plaques. An enormous saccular aneurysm proceeded from the back of the lower part of the thoracic aorta to occupy the whole of the right base. The neck of the sac admitted the closed fist and the margin was bounded by a calcareous ring. The lower four dorsal vertebræ were extensively eroded, as were the last two ribs. The œsophagus, lying in front of the aorta, was apparently unaffected.

I am indebted to Dr. A. Lionel Baly, our medical superintendent, for permission to publish this case, and I also wish to thank Mr. Trotter for his courtesy and kind services in connexion therewith.

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TWO CASES OF FRONTAL SINUSITIS WITH BONE COMPLICATIONS.

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I PUBLISH these cases to show the varying conditions of bone complications one may meet with in this condition.

CASE 1.—I was consulted in January, 1911, by a girl, aged 19, who complained of very severe pain over the left eye and headaches of two weeks' duration. She had been troubled with nasal catarrh for many years, and had had adenoids removed nine weeks previously. There was no pus to be seen in the nose and an attempt to catheterise the sinus failed. Her temperature was 100° F. Palliative measures failing to give relief, I opened the sinus on Jan. 28th. The mucous membrane was much swollen and intensely congested. No pus was present, but much mucus secretion was evacuated. The temperature soon fell to normal and the pain disappeared. The tube was removed two days later, and the patient remained well for five days. On Feb. 5th she suddenly complained of severe frontal and occipital pain accompanied by retching and vomiting. Her features became swollen and puffy and her temperature ran up to 104°. The pain was especially marked over the left vertex, where there was intense tenderness with slight bogginess. The frontal wound remained healed and clean, and there was no suggestion of an erysipelatous infection. The sinus was reopened and freely drained. Pus was still absent. That evening the temperature rose to 105·4°, although the headache was somewhat relieved. The retching continued, and the patient remained seriously ill. Some cerebro-spinal fluid drawn off by lumbar puncture was kindly examined by my colleague, Dr. A. E. Barnes, and found to be normal. This condition of the fluid, together with the absence of increased pressure in the cerebro-spinal sac, made it improbable that the symptoms were due to any intracranial complication. A blood count showed 21,500 white cells. The temperature gradually fell and the other symptoms abated. Pus began to drain freely from the wound and on the 14th the temperature was normal. She remained well until February, 1912, when, owing to a recurrence of the frontal pain and headache, a radical operation was performed on the left frontal sinus and ethmoidal cells, which resulted in complete recovery.

CASE 2.—This case was that of a man, aged 42, who complained of pain and swelling over the right side of the forehead of eight weeks' duration. When I first saw him, in November, 1912, the swelling was circumscribed, fixed and firm, with no bogginess or implication of the skin. There was no pus to be seen in the nose, but there was marked nasal obstruction caused by hypertrophy of the turbinals and a large left septal ridge and spur. The swelling eventually showed signs of fluctuation, and pus, infected with bacillus pyocyaneus, was evacuated. On Nov. 25th I did a radical operation on the right frontal sinus. There was a large bony erosion of the anterior wall and a smaller one on the floor of the sinus. The sinus was filled with pus. The remainder of the anterior wall, which was carious, and the floor were