segment. This is often successful, even in the senile obliterations, in improving the vegetative state of the limb and so protecting against gangrene. Its effect on intermittent claudication—the commonest disabling symptom—is much more uncertain. In many cases no improvement in the claudication follows an otherwise satisfactory sympathectomy. Some of the results of disobliterative endarterectomy suggest that this may have a more direct effect on claudication than can be achieved by dilatation of the collateral vessels. Thus in one of my cases claudication was completely relieved by endarterectomy of the femoral artery several months after a lumbar ganglionectomy which had had no effect on this symptom. In another case, with bilateral claudication, a lumbar sympathectomy was performed on one side and a femoral endarterectomy on the other (Forty, 1951). The relief of the claudication was much greater on the side treated by endarterectomy.

An essential preliminary to disobliterative endarterectomy is a good arteriogram demonstrating a localized thrombosis in a main artery with a permeable lumen beyond it. In these circumstances the operation is indicated, provided that the patient's general condition warrants a longish intervention under general anaesthesia, with special reference to the risk of post-operative coronary or cerebral thrombosis in elderly arteritic persons. Cerebral thrombosis 10 days after operation caused the one death in my personal series of eight disobliterative operations.

Severe haemorrhage from the wound may result from the administration of heparin. In one of my cases of disobliteration of the whole length of the femoral artery and beginning of the popliteal artery the wound had to be reopened five hours later because of severe bleeding. The femoral artery was seen pulsating well at the bottom of the wound, and the suture line was intact. The haemorrhage was due to capillary oozing from the muscles and fasciae, and was controlled by packing. Secondary suture of the wound, performed four days later, was followed by good healing and a satisfactory functional result.

Summary

A case of successful disobliterative endarterectomy of the external iliac artery is reported.

The technique, indications, and complications of the operation are briefly discussed.

My thanks are due to Miss M. H. Shaw for the photograph.

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Cambridge University Press has published *Alumni Cantabrigienses* (vol. 4, part 2) a biographical list of students, graduates, and holders of office at the University from the "earliest times" to 1900. Biographies are necessarily short, but many entertaining details emerge (*Nature*, July 26, p. 131). A high proportion of members went into the Church; the Rev. Edward Kempe is said to have left behind him a ton of unpreached sermons. Diplomat Henry Labouchere contracted a debt of £6,000 in two years at Cambridge, joined a circus, lived in a Red Indian camp, was dismissed from the diplomatic service for impertinence to Lord John Russell, became an M.P., and then a successful journalist working for the *Daily News* and *Truth*. About 90 Fellows of the Royal Society are mentioned; other famous scientists include Le Verrier, Lister, and Sir John Murray. A large number of graduates were Fellows of the Society of Antiquaries—the Earl of Crawford, for instance, founder of Dunecht Observatory, who went to Mauritius to observe the transit of Venus in 1874. Another who travelled far from Cambridge was James Losh, who went to Paris to study the French Revolution and had his life saved by Marat, who had been a practising physician in London. On his 103rd birthday C. F. L'Oste, who had never consulted a doctor, went up in an aeroplane.

CONGESTIVE SPLENOMEGALY DUE TO PANCREATIC CYSTADENOMA

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Cystadenoma of the pancreas appears to be an uncommon condition, to judge by most publications. Not all authors agree to this, however: Haukohl and Melamed (1950) point out that, while they could find only 63 authentic cases in the literature, many others were "buried in reports on pancreatic surgery, hidden in discussion of wholly unrelated non-neoplastic conditions, or reported under a variety of erroneous diagnoses." Study of the available literature indicates that most of the recorded cases presented as problems in surgical or radiological diagnosis, because of either abdominal pain or a palpable tumour.

We should like to add another case, not only because of the uncommonness of the condition but also on account of the nature of the symptoms which have not previously been noted.

Case Report

The patient was a woman aged 39, who was first seen by us in October, 1947, when she was admitted after a severe haematemesis. She said she had vomited blood for the first time in 1939, when a diagnosis of peptic ulcer was made; and she had had melaena nine months before admission. Apart from these episodes her only other complaint was of intermittent vague epigastric discomfort which bore an inconstant relationship to food. Her appetite was good and she had not lost weight.

On examination she was pale and moderately shocked; there was a little tenderness in the epigastrium. The spleen was readily palpable below the left costal margin. The lungs and cardiovascular system were normal apart from a blowing systolic murmur at the apex of the heart. A blood count showed: haemoglobin, 42% (Haldane); red cells, 2,300,000 per c.mm.; white cells, 5,000 per c.mm. (polymorphonuclear 84%, lymphocytes 15%, monocytes 1%); the film showed moderate anisocytosis and abundant platelets. One pint (570 ml.) of group O rhesus-negative blood was transfused as an emergency measure; subsequently she responded well to oral iron. Bleeding and coagulation times and red-cell fragility were normal. No abnormality was found in the bone marrow apart from rather overactive haemopoiesis. The van den Bergh reaction was negative, and there were no abnormal urinary pigments. Films of material obtained by spleen puncture did not reveal any pathological tissue. Fractional gastric analysis showed moderate hypochlorhydria; barium swallow and meal failed to demonstrate oesophageal varices or ulceration in the stomach and duodenum.

The patient was discharged after six weeks in hospital with a diagnosis of congestive splenomegaly; the haemoglobin level was 84% (Haldane). Between October, 1947, and August, 1949, she was admitted to hospital six times—on four occasions with haematemesis, once with melaena, and once because of lassitude and lack of energy resulting from prolonged occult bleeding in the gastro-intestinal tract. Her condition at these times varied; blood transfusion was

required more than once, and she was taking oral preparations of iron in the intervening periods.

In August, 1949, it was felt that, in view of these repeated haemorrhages, surgical intervention offered the only hope of cure. She was admitted to the Royal Southern Hospital, Liverpool, in October, being then in reasonably good health. The only abnormal physical sign was the enlarged spleen, which extended well below the costal margin. The blood count was: haemoglobin, 89% (Haldane); white cells, 5,000 per c.mm., with a low normal polymorphonuclear count and a mild lymphopenia; platelets, 100,000 per c.mm. Repeated tests for occult blood in the faeces were negative. The galactose tolerance and hippuric acid synthesis tests revealed no evidence of liver insufficiency. Oesophagoscopy on October 15 showed that there were no oesophageal varices, but it was noted that the gastric mucosa bled very easily.

Laparotomy was performed on October 24 by Mr. J. Cosbie Ross. When the abdomen was opened a large cystic mass was found arising from the body and tail of the pancreas; the cyst stretched and compressed the splenic vein, resulting in engorgement of the spleen and vasa brevia, with consequent hyperaemia of the gastric mucosa. To facilitate removal of the cyst, splenectomy and partial resection of the tail and body of the pancreas had to be carried out. The wound was closed with drainage.

Convalescence was satisfactory, though for a short time there was a raised fasting blood sugar with occasional glycosuria. On the sixteenth day after operation a glucose-tolerance test showed that the blood sugar was 200 mg. per 100 ml. half an hour after ingestion of 50 g. of glucose. The hyperglycaemia and glycosuria gradually subsided, however, and when the patient was discharged 12 days later carbohydrate tolerance was within normal limits.

Pathological Histology.—The cyst removed at operation measured 12 by 10 by 8 cm. Its surface was smooth and lobulated, and intimately connected with the tail and body of the pancreas, the splenic vessels being stretched over it. Microscopically, the tumour tissue showed the picture of a well-formed, regular mucus-secreting cystadenoma with no evidence of malignancy. The pancreas was normal except for a little dilatation of the ducts. The spleen weighed 280 g., and had the typical appearance of early so-called "Banti's syndrome." The rather small size of this organ was probably accounted for by manipulation during removal.

Discussion

The chief interest in this case lies not so much in the rarity of the pathological condition as in the nature of its manifestation. Among the previously recorded cases the most common symptoms were (a) pain, generally of a vague character, and indefinitely related to meals; (b) dyspeptic symptoms attributable to disease in the biliary tract, such as gallstones; (c) a palpable mass; (d) a diabetic syndrome of variable severity (Carling and Hicks, 1925; Bowers *et al.*, 1942; Benson and Gordon, 1947; Jemerin and Samuels, 1948; Herrman and Asbell, 1949; Johnson and Gibson, 1950). In all these cases one or other of the first three complaints caused the patient to come under the care of a surgeon from the outset; the diabetic state was usually associated with the main symptom, and indicated that the pancreas was involved in the pathological process.

We have not been able to find any reference in the literature to gastro-intestinal haemorrhage as a symptom except in one case quoted by Malcolm (1906). In our case haematemesis and melaena were the outstanding features, and at no time after she came under our care was the patient troubled by pain or dyspepsia. The tumour mass was never palpable, although careful abdominal examination was carried out on many occasions by different observers. Glycosuria appeared for the first time after operation. There was therefore no clear-cut indication for surgery until the eventual decision was made with the object of

reducing the portal hypertension. In fact, the presence of the enlarged spleen was regarded as sufficient reason for conservative treatment.

The term "Banti's syndrome" is no longer fashionable, and has been generally abandoned in favour of the definitive terminology of "congestive splenomegaly" or "hepatolienal fibrosis." As Learmonth (1951) points out, neither of these terms is entirely suitable, for in a small number of cases intrahepatic or extrahepatic block cannot be demonstrated, and the liver may be apparently normal. In the present case, however, the liver was macroscopically and biochemically unaffected, while the splenic vein was obviously obstructed by the tumour; therefore congestive splenomegaly would seem to be the correct term to apply.

The point we wish to make is that surgical intervention should be considered in all cases of congestive splenomegaly, and it should be borne in mind that a tumour (as in this case) may be the underlying cause of the condition; if this is the case the prognosis is good.

We should like to express our thanks and indebtedness to Dr. R. W. Brookfield and Mr. J. Cosbie Ross, Royal Southern Hospital, Liverpool, who kindly took over the subsequent care and treatment of the patient.

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Medical Memoranda

A Very Slowly Developing Hypernephroma

The following case of hypernephroma is worthy of publication, as it possessed several interesting features.

CASE REPORT

A man aged 55 was first seen by one of us (R.P.) on September 26, 1944, complaining of pain and stiffness in the muscles of his right shoulder-girdle. There was limitation of voluntary and involuntary movement at the right shoulder-joint, with marked muscle wasting. His blood pressure was within normal limits, and his urine contained much albumin. On October 14, before he had seen a specialist, he had a urethral haemorrhage with retention of urine. His prostate was not enlarged. He was passing a little urine and clots per urethram. On catheterization a large quantity of dark blood-stained urine was obtained, and next day he was admitted to hospital. X-ray examination showed a secondary tumour in the upper end of the shaft of the right humerus, with a spontaneous fracture, and the left kidney was reported much enlarged. As treatment was regarded as of little avail, he was sent home to die on October 18 with a diagnosis of hypernephroma of the left kidney and metastasis in the right humerus.

He had a good deal of pain in his right shoulder and looked very sick; we decided to try stilboestrol therapy, 5 mg. thrice daily. Within a week clinical improvement was noted. His colour was better, he had less pain in his right shoulder, there were no urinary symptoms, and only a trace of albumin was demonstrated in the urine. As he had improved so much he was seen again at the hospital on January 5, 1945, when the growth in the humerus was larger than before, and red cells were still demonstrable in the urine. The patient, however, continued to improve clinically; he put on weight and had a good appetite. He