Summary

Four patients suffering from virilism due to adrenocortical hyperplasia were treated with cortisone, hydrocortisone acetate, prednisone, or prednisolone for periods ranging from six to eighteen months. Oral cortisone was effective in reducing to normal the 17-ketosteroid excretion in the two younger patients, aged 3½ and 16 years, but was ineffective in the two older patients, aged 19 and 20 years.

Prednisone and prednisolone were the most active in depressing the 17-ketosteroid levels, prednisone being about five times more potent in this respect than oral cortisone and having from two-thirds to three-quarters of the activity of prednisolone.

Hydrocortisone acetate injected intramuscularly weekly or fortnightly was also effective.

Growth of excess hair was retarded to some extent; acne disappeared in three patients in whom it was present; and menstruation was established in one patient with secondary amenorrhoea.

We are indebted to Ciba Laboratories Ltd. for supplies of prednisone ("ultracorten").

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Medical Memorandum

Atrial Septal Defect with Mitral Stenosis (Lutembacher's Syndrome) in a Woman of 81

Longevity in any form of congenital heart disease is rare, but probably is most often met with in atrial septal defects associated with mitral stenosis (Lutembacher's syndrome). Askey and Kahler (1950) describe the case of a man with this syndrome who lived to the age of 72 in spite of auricular fibrillation for the last 15 years. They also quote the classical case of Firket (1880), a woman who had eleven pregnancies and three abortions and died at the age of 74; and those of Bonnabel (1906), two patients who lived to be "over 70." Sailer (1936) describes the condition in a man of 67, and Pyke and Symons (1951) in a man aged 72. Increasing interest in both geriatrics and congenital heart disease will probably result in the discovery of many more such cases, but meanwhile the following case of Lutembacher's syndrome in a woman of 81 seems to be worthy of record.

CASE REPORT

The patient was admitted to hospital on December 12, 1954, with a diagnosis of "bronchitis with heart failure." Signs of heart failure first began to show in 1948 when a blood pressure of 180/110 mm. Hg was noted. In 1950 she had oedema of both legs and an apical systolic murmur was heard over the praecordium. The pulse was regular at that time. Albuminuria was noticed in 1951 and the regular doses of mersalyl she had been having were discontinued. In 1953 the legs again became oedematous and it was neces-

sary to restart treatment with mersalyl. She had taken to her bed about a week before admission because of vague pain across the lower part of the chest and a distressing cough. Her previous history was otherwise unhelpful. She had no serious illnesses before 1948 and there was no history of rheumatic fever. She had had six normal pregnancies and no miscarriages. Three sons were alive and well, one son had died at the age of 18 months, and two daughters had died from "pneumonia" both at the age of 28.

On examination she was sensible but depressed. There was slight cog-wheel rigidity at the wrists and her facial expression resembled that of early Parkinsonism. She had no oedema, anaemia, or clubbing of the fingers, and her pulse was irregular at a rate of 96 per minute. The apex beat could be felt in the axilla and a loud systolic murmur heard over the apex. The blood pressure was 180/120 mm. Hg. A few scattered dry sounds were heard in the chest and fine moist sounds over the lower lobe of the right lung. There were no other abnormalities on systemic examination. The urine showed a trace of albumin and scanty hyaline and granular casts. Radiography of the chest was reported on as follows: "The transverse diameter ratio is 14/22 cm. The enlargement of the heart is mainly to the left, and the middle portion of the left border shows a smooth convexity. The aortic knuckle is enlarged and shows atheromatous calcification. The right hilar shadow is markedly increased, the left hilar shadow being concealed by the cardiac outline."

In spite of treatment the congestion of the lungs became progressively worse and she died on January 5, 1955.

Post-mortem examination was restricted to the thorax and abdomen. There was hypertrophy of the left ventricle; the right auricle was dilated and the left auricle normal. Of the valvular openings only the mitral showed macroscopic changes; severe stenosis was present admitting the tip of the little finger. The mitral ring was calcified in part. In the interatrial septum was a roughly circular defect measuring 2 cm. across. The aorta was of normal size and atheromatous. The pulmonary artery was dilated and showed a little atheroma, the right branch being partly occluded by an organized ante-mortem thrombus thought to be a few weeks old. The bronchi showed chronic inflammatory changes and both lungs were very oedematous, the right one with several superficial infarcts. The kidneys were of equal size, scarred and atrophic, with atherosclerosis of the vessels. The left renal artery was partly occluded by a large atheromatous plaque. There were no other changes of note.

LIFE EXPECTANCY

McGinn and White (1933), in reviewing 24 patients with atrial septal defect and mitral stenosis, found the average age at death to be 35 years. Roesler (1934), examining 62 patients with atrial septal defect 30 of whom had definite mitral stenosis in addition, found the expectancy of life to be 36 years. In spite of this there are examples on record to show that the septal defect may coexist with mitral stenosis and the patient live a tolerable life well beyond this expectancy. The patient described brought up a family of six children and lived a very active life for 75 years before signs of heart failure appeared and from which she died six years later. How such a combination of lesions, both of which may be of a severe degree, can allow of such a long and useful life is ill understood.

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