Medical Memoranda

Xanthoma Palpebrarum and Cardiovascular Disease

The accompanying family tree, which is self-explanatory, may prove interesting. The conjunction of xanthoma palpebrarum and cardiovascular disease in three generations seems remarkable in view of the wide distribution

of cholesterol in the tissues and the variety of disease syndromes that could accompany disturbance of lipid metabolism.

Nine members of the second generation were victims of cardiovascular disease. The two remaining brothers had heart disease, but one died from diphtheria, and the information available regarding the other is not sufficient to enable me to be definite about the cause of death.

Sir John Parkinson saw No. 8 five years before her death. He has kindly allowed me to quote from his report and from a later full review of the cardiovascular aspects of the case. I am taking advantage of his offer so as to make this patient's cardiovascular picture clear, and so give a good idea of the disease as it affected the other members. The uniformity of symptoms throughout the group is striking. Sir John notes: "For a few years Mrs. X has been more breathless on exertion, and for 18 months she has also had an upper sternal pain extending into the left arm. This is related to exertion or excitement, and otherwise she is pretty well. Signs on examination are few. The blood pressure is 150/80. Radiographs show no cardiac enlargement. The electrocardiogram does point to coronary disease." In a later review of the case he writes: "It was my opinion that your patient, Mrs. X, had angina of effort. The electrocardiogram shows in Lead I some R-T depression with a diphasic T wave; there is a corresponding S-T elevation in Lead III. This combination, with slight widening of the QRS, seen best in Lead II, points to coronary disease. There was no evidence that she had hypertension then."

Two years later her blood pressure rose and for a time remained at 200/100 and her cardiac reserve fell further, pain coming on slight exertion and sometimes waking her at night. Her blood pressure later fell to 150/100. She died from coronary thrombosis.

Of four sibs of the third generation, one had extensive xanthoma palpebrarum, angina, dyspnoea on exertion, and hypertension. Symptoms increased slowly over 10 years. Death occurred from coronary thrombosis. Two others had cardiac disease, and both died suddenly.

Other diseases associated with hypercholesterolaemia were not in evidence, nor was any extension of the xanthoma noticed except in Case 8, in which yellow glistening patches appeared under the mucous membrane of the underside of the tongue, accompanied by superficial glossitis. Her cholesterol was 345 mg. per 100 ml., and

the Wassermann reaction was negative. In a member of the third generation presenting no clinical signs or symptoms the cholesterol is 230 mg. per 100 ml.

I am grateful to Sir John Parkinson for the use of his reports, and to Dr. Vaughan Facey for reports and cholesterol estimations, and permission to use them.

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BIBLIOGRAPHY

- Darier, J. (1928). *Précis de Dermatologie*, 4th ed., p. 1015. Masson, Paris.
Engelberg, H., and Newman, B. A. (1943). *J. Amer. med. Ass.*, **122**, 1167.
Jones, E. S., and Robertson, P. W. (1948). *British Medical Journal*, **1**, 1137.
MacKenna, R. M. B. (1948). *Modern Trends in Dermatology*. Butterworth, London.
O'Leary, P. A., and Montgomery, H. (1947). *Coll. Pap. Mayo Clin.*, **39**, 374.
Weber, F. P. (1948). *British Medical Journal*, **1**, 1254.

Acute Volvulus of the Stomach

Volvulus of the large intestine is fairly common, volvulus of the small intestine is much rarer, while volvulus of the stomach is very uncommon.

In 1927 Laeven summarized 40 cases of volvulus of the stomach, since when very few additional cases have been recorded. In a review of the literature the following points are stressed: (1) ptosis of the stomach with laxity of its ligaments causing a greater distance between the diaphragm and the stomach; (2) gastric disturbance associated with excessive peristalsis; and (3) congenital weakness of the left side of the diaphragm.

CASE REPORT

A man aged 42 was admitted to hospital on January 3, 1945, complaining of agonizing pain in the upper epigastric region. It had started about four hours before admission whilst he was drinking a glass of beer. He had had stomach pain and flatulence after meals for 12 months.

On examination the appearance of the abdomen was striking, it looked as if he had a football within the upper part of his peritoneal cavity. The rest of the abdomen was of normal size. As the patient was in agonizing pain, a large dose of morphine was given and arrangements were made for an immediate laparotomy. The pulse was 80 and the temperature 97° F. (36.1° C.). The swelling was resonant on percussion. Various diagnoses were made, the nearest being that of volvulus of the large intestine.

Operation.—The abdomen was opened by a left upper paramedian incision under general anaesthesia, and a large tense gaseously distended swelling the size of a football was found. The stomach was seized with $\frac{1}{2}$ -in. (1.25-cm.) Duval forceps and a large trocar inserted to relieve the gaseous distension. After all the gases had escaped, the gastric puncture was closed. It was then found that the pyloric end of the stomach, which was very movable, was twisted anteriorly and to the left, lying in the left flank by the spleen, whilst the cardiac end and the adjoining oesophagus was wound round the pylorus and was under the right costal margin. The stomach was twisted and obstructed at both the cardiac and pyloric ends.

After the gastric distension had been relieved the volvulus of the stomach untwisted itself in an anticlockwise direction, which brought it into its correct position. The Duval forceps which had been applied to the stomach and were lying to the left of the abdomen suddenly moved towards the right side. The volvulus had been cured by the simple process of relieving the gastric distension. The anterior part of the stomach was fixed to the anterior peritoneal wall and the abdomen was closed in layers. For several days the abdomen remained very distended and a Ryle's tube was kept in the stomach to relieve this.

Three weeks later the patient left hospital quite well. A small incisional ventral hernia had to be cured twelve months later. He has remained well ever since, has had no symptoms, and has been able to resume his work as a full-time fitter.

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