perineum, and the thighs. There was a moderate degree of shock on admission. His general condition improved with suitable measures, and the scalds were cleansed and then dressed with sulphanilamide cream, and sulphanilamide tablets were given by mouth. During the next three days he had a temperature ranging between 99° and 100° F. (37.2° and 37.8° C.) and a pulse rate which on the evening of Aug. 27 suddenly rose from 90 per minute to 140. There was no vomiting or tenderness in the abdomen. The bowels did not move. The next day the bowels moved, but no blood was noticed in the stool. The pulse still remained around 130, and it was noticed that the child was a little restless. On Aug. 30, in the forenoon, he suddenly passed a very large amount of dark-coloured blood per rectum and a little later vomited a small amount of dark-coloured blood. His general condition deteriorated rapidly, and in spite of measures to replace fluid loss he died the same night.

It is now evident that the haemorrhage must have started insidiously on the evening of Aug. 27, approximately 30 hours after the injury; its insidious onset and progress passed unnoticed until the occurrence of the large melaena and haematemesis, which only then drew attention to the fact that haemorrhage was occurring somewhere high up in the intestinal tract, probably in the duodenum.

At necropsy the intestine was found to be full of blood clot, the organs were pale and exsanguinated, and an acute ulcer was present in the second part of the duodenum 2.5 cm. proximal to the ampulla of Vater on the postero-medial wall. The ulcer was circular, about 1.5 cm. in diameter, with shelving walls, and extended down to the muscular coat; in the floor of the ulcer a small eroded artery was found from which apparently the haemorrhage had come.

Curling's ulcer is probably more common than is realized; it is fair to assume that not all the cases diagnosed will be reported, and it will be diagnosed only in the event of haemorrhage, perforation, or necropsy, and presumably these do not occur in every case.

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A Case of Arteriovenous Aneurysm

The following case of arteriovenous aneurysm between the ascending aorta and the superior vena cava is described because of the rarity of this condition.

CASE HISTORY

A Chinese labourer aged 42 was admitted to the General Hospital, Singapore, on Aug. 22, 1947. The history given was that on the previous day at about 7 a.m., while carrying a bucket of water, he felt a sudden pain over the front of the neck; this was followed by swelling of the neck, dusking of the face, and difficulty in breathing.

He looked very ill and presented a dramatic picture—sitting up in bed, gasping for breath, hardly able to talk, dusky over the face, neck, shoulders, and upper half of the thorax, with some swelling and induration of the soft tissues over these areas. A marked continuous thrill was felt immediately above the inner third of the right clavicle. Percussion did not reveal any enlargement of the heart. The sounds were rapid and regular, with accentuation of the second aortic. A continuous loud machinery murmur with systolic accentuation was heard over the heart and all over the chest anteriorly; it was loudest over the area of the thrill in the right supraclavicular region. This murmur disappeared when firm digital pressure was applied

over the area of the thrill. The blood pressure on the right side was 130/70, on the left side 126/70. Examination of the lungs showed some diminution of breath sounds over the right side. The inguinal lymph nodes were enlarged. There were no genital scars. No abnormality was discovered in the abdomen or the nervous system.

A diagnosis of arteriovenous aneurysm between the aorta and superior vena cava was made. Death ensued after three hours. As he was dying the dusky appearance of his face faded away.

Necropsy.—The heart was normal in size, with post-mortem clots in all the chambers. The muscle was reddish brown in colour and firm. The valves were normal and competent. Pearly-white linear scars of syphilis were present at the root of the aorta and along the arch. At the junction of the ascending and transverse portions of the arch was an aneurysmal dilatation, the sac of which measured 8 cm. in diameter, with an inlet 4 cm. in diameter (Fig. 1); it was adherent to the upper lobe of the right lung. The sac had ruptured into the upper portion of the superior vena cava (Fig. 2). All the large veins of the neck were greatly dilated. Other organs showed congestion.

COMMENT

This is a typical case of spontaneous arteriovenous aneurysm within the thorax. The perforation occurred suddenly during exertion and was followed soon after by evidence of obstruction of the superior vena cava. The thrill and murmur were characteristic of an arteriovenous communication. The heart showed no evidence of enlargement, as the aneurysm did not involve the aortic ring. The aetiological factor was syphilis. Out of the 23,000 necropsies performed during the last twenty years in the Department of Pathology, Singapore, this is the first case of a thoracic arteriovenous aneurysm.

I am indebted to Dr. T. Balasingham for the necropsy report.

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FIG. 1.—A, Aneurysmal sac. B, Left ventricle.

FIG. 2.—A, Opening into superior vena cava. B, Aneurysmal sac. C, Right auricle.