Laboratory Findings

	Day of Disease				2 Months after Clinical Recovery (85th Day)
	5th	10th	14th	23rd	
Erythrocytes (per c.mm.)	5,990,000	4,910,000	4,530,000	4,630,000	5,590,000
Haemoglobin (g.%)	16.6 (120%)	13.6 (98%)	12.4 (90%)	12.7 (92%)	15.5 (112%)
Colour index	1.00	1.00	0.99	0.99	1.00
Leucocytes (per c.mm.)	15,300	9,450	8,700	8,600	6,800
Polymorphs	19.0%	—	28.3%	37.25%	55.3%
Eosinophils	0%	—	1.0%	4.25%	4.7%
Basophils	0.3%	—	0.3%	0.5%	0.7%
Lymphocytes	38.7%	—	59.0%	43.75%	33.0%
Monocytes	31.7%	—	9.7%	14.25%	6.3%
Atypical "mononuclear cells"	10.3%	—	1.7%	0%	0%
Total mononuclear cells	80.7%	—	70.4%	58.0%	39.3%
Platelets (per c.mm.)	N	202,000	N	N	N
Prothrombin time	—	13 secs.	—	—	—
Prothrombin time (normal control)	—	15 secs.	—	—	—
Heterophile antibody (Davidsohn's technique)	—	1:448	—	—	—

N = Normal in films.

himself at hospital and was admitted at once. An immediate sigmoidoscopy merely confirmed the occurrence of active bleeding from above the pile-bearing area of the rectum, but failed to locate an actual bleeding site.

Treatment was conservative and consisted of complete rest in bed, a strict ulcer diet, and 10 mg. of vitamin K three times a day. During the night following admission one motion consisting almost entirely of clotted blood was passed. From then onwards active bleeding stopped. Altered blood in diminishing quantities was present for two more days, after which the faeces became normal and clinical progress was rapid. It is estimated that the total blood loss sustained during the 36 hours of active though intermittent bleeding amounted to at least $\frac{1}{2}$ pint (284 ml.).

On the fifteenth day sigmoidoscopy was repeated after proper medical preparation. The instrument was passed to 1 in. (2.5 cm.) beyond the pelvi-rectal junction, where faecal matter was encountered. A thorough search failed to show any abnormality of the rectum. Finally, a full radiological examination of the alimentary canal, including barium enema and "follow-through," was carried out, again without revealing any pathological condition.

The patient was discharged on the twenty-second day after the onset of symptoms. At that time the enlargement of the lymph glands and spleen had almost completely subsided. There has since been no recurrence of the bleeding, and the patient has remained well up to the time of writing—a period of over twelve months.

Discussion

Haemorrhagic manifestations varying from epistaxis to purpuric lesions are well recognized among the rarer complications of infectious mononucleosis (Tidy and Morley, 1921; Downey and McKinlay, 1923; Bernstein, 1940). However, rectal bleeding seems to be almost unknown. It is not mentioned in any of the current textbooks or in recent reviews (e.g., Contratto, 1944; Bethell, Sturgis, Rundles, and Meyers, 1946; Gardner and Paul, 1947). Only two instances were found in the literature. In 1934 Tidy made reference to the occurrence of "rectal haemorrhage with bright blood in a child" without giving any further details. Israëls (1937) reported recovery from a "single quite considerable haemorrhage from the rectum after defaecation" in a woman aged 21, but this particular case presented various unusual features and was further complicated by the fact that the patient was known to possess a definite bleeding tendency.

The association of rectal haemorrhage with the attack of glandular fever here recorded is suggestive though not

conclusive, and no claim can be made that a definite causal relationship between them has been established. On the other hand, the patient gave no history of a haemorrhagic diathesis and has shown no signs of a recurrence since his recovery. Unfortunately, the bleeding and clotting times were not determined, but clinically there was no evidence of purpura, and the normal prothrombin and platelet findings go far to rule out the existence of a bleeding state. A very thorough search for alternative and more usual causes of intestinal haemorrhage was made by means of the sigmoidoscope and radiographs; there can be few pathological conditions (with the possible exception of a minute haemangioma or telangiectatic focus) that would escape detection when so investigated. There was no personal or family history of telangiectasis. Other rare factors like congenital diverticula can probably be excluded in view of the patient's age.

Summary

The occurrence of rectal haemorrhage during a mild bout of infectious mononucleosis was observed in a man aged 34.

The bleeding resulted in a loss of over half a pint of blood and was not accompanied by significant thrombocytopenia or hypoprothrombinaemia. Thorough investigation of the alimentary canal by sigmoidoscopy and radiographs revealed no pathological condition which might have accounted for the haemorrhage. Recovery was apparently complete, and there has been no recurrence of the bleeding for a period of more than twelve months.

We wish to thank Mr. B. N. Brooke, of the Department of Surgery, Queen Elizabeth Hospital, for his permission to publish this account and for access to the case notes.

REFERENCES

- Bernstein, A. (1940). *Medicine*, **19**, 85.
 Bethell, F. H., Sturgis, C. C., Rundles, R. W., and Meyers, M. C. (1946). *Arch. intern. Med.*, **77**, 80.
 Contratto, A. W. (1944). *Ibid.*, **73**, 449.
 Downey, H., and McKinlay, C. A. (1923). *Ibid.*, **32**, 82.
 Gardner, H. T., and Paul, J. R. (1947). *Yale J. Biol. Med.*, **19**, 839.
 Israëls, M. C. G. (1937). *British Medical Journal*, **1**, 601.
 Tidy, Sir H. L. (1934). *Lancet*, **2**, 180, 236.
 — and Morley, E. B. (1921). *British Medical Journal*, **1**, 452.

DISSECTING ANEURYSM OF THE AORTA SIMULATING EMBOLISM AT THE AORTIC BIFURCATION

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The details of a fatal case of a dissecting aneurysm of the aorta are here recorded. At one stage an embolus near the aortic bifurcation was suspected, and during a phase of recovery coldness of the skin over an area proximal to the ankles persisted longer than coldness of the feet.

Case Report

A man aged 66 who had had a coronary thrombosis 15 years previously was seized with an agonizing pain round the upper abdomen and also low down in the back while chasing cattle. An hour later a severe pain developed in the left thigh and calf, followed in half an hour by similar pain in the right limb. He collapsed and could neither feel nor move his legs. Four hours after the onset of the illness the pulse was regular, the

blood pressure was 130/100 mm. Hg, and auscultation of the heart did not reveal any abnormality.

Left Lower Limb.—The colour was normal, active movement was present only in the left great toe, the left common femoral pulse was present though small in volume, but the posterior tibial and dorsalis pedis pulses were absent. The skin was anaesthetic as far up as the lower abdomen and was cold from the knee downwards. The knee and ankle reflexes were absent.

Right Lower Limb.—The leg was pale from the knee downwards; there were no active movements and the common femoral pulse was absent. The skin was anaesthetic as far up as the middle third of the thigh and was cold from the knee downwards. The reflexes were absent.

Five hours after the onset of the illness there was no change in the right limb, while in the left full movement had returned and the only abnormalities were absence of the posterior tibial and dorsalis pedis pulses and coldness of the skin below the mid-shin, including the foot. Two hours later the skin above the left ankle was still cold, while the thigh and foot were warm. There had been full recovery of movement in the right limb, and the common femoral pulse was now present and was larger in volume than the left; coldness was found on the dorsum of the foot and as far as the knee, while the toes were warm. Oscillometer readings were as follows:

	Thigh		Calf	
	Right	Left	Right	Left
180 mm. Hg ..	3½	1	2½	1
160 " " ..	5	1	4	1
140 " " ..	5½	1½	5	1
120 " " ..	5	2	6	1
100 " " ..	4½	1½	6	1
80 " " ..	3	1	5	1½

The areas of coldness showed no further change until 14 hours after the onset, when the whole of the right foot was warm, but coldness of the skin above each ankle remained for several hours longer.

The following day the limbs were normal except for the difference in common femoral pulsation. The blood pressure had risen to 260/140, but the patient was cyanosed and breathless, and he died 48 hours after the onset of the illness.

Limited Necropsy.—A dissecting aneurysm started in the first part of the aorta, involved the abdominal aorta, and extended as far down as the middle of the right common iliac artery. There was a large atheromatous plaque in the right common iliac artery at the same level as the lower margin of the extravasated blood. The left common iliac artery was normal. The dissecting aneurysm extended about one-third of the way round the ascending part of the aorta and a quarter of the way round the right common iliac artery. There was a large collection of blood in the pericardium and of blood-stained fluid in the left pleura.

A large fibrotic area was present in the mid-posterior zone of the heart, due to an old coronary thrombosis, and there was advanced coronary atheroma, particularly of the anterior descending branch. No evidence of a recent infarct was found. The middle of the aorta and the femoral arteries were not examined.

Discussion

The difficulty in diagnosis of the vascular cause of sudden pain and paralysis in a limb is the element of arterial spasm which may occur both in embolus and in dissecting aneurysm; a dissecting aneurysm may also directly interfere with the blood supply of the spinal cord. The only constant findings in embolus are absence of the peripheral pulse, lowered surface temperature, and pallor (Allen, Barker, and Hines, 1946). The initial physical signs suggested an embolus completely blocking the right common iliac artery and partially blocking the left, but the fact that symptoms on the left preceded those on the right by

half an hour made this unlikely, and rapid and marked improvement of the condition of the limbs finally excluded embolus and ischaemia of the cord.

The changes in the surface temperatures over different parts of the lower limbs merit emphasis. In both limbs the last area of skin to warm up was not over the foot but over the area surrounding the leg just above the ankle. This area remained cold for some hours while the foot and calf were warm. Dr. John Homans told one of us (H.S.S.) that it was not uncommon after anaesthetizing the lumbar sympathetic ganglia to find the first area in the limb to warm up is behind and above the malleoli, a reaction which takes place well in advance of the temperature changes in the toes. The delayed vasodilatation in the area of skin proximal to the ankle in this case and the early vasodilatation in the same area following lumbar sympathetic block point to a peculiarity in the arteriolar pattern which may be related to the formation at this site of ulcers that are variously labelled varicose, post-phlebitic, or gravitational.

Summary

In a case of dissecting aneurysm of the aorta there was marked spasm of the lower limb arteries, with coldness and paralysis of the legs simulating embolism at the aortic bifurcation. In the recovery phase the last portion of the skin in each leg to become warm was a localized area of the skin just above the ankle. It is suggested that there may be an exceptional vascular arrangement at this site, possibly related to the occurrence of ulcers of the legs.

We are grateful to Dr. G. F. Fowler and Dr. C. V. Light for their help with this case.

REFERENCE

Allen, E. V., Barker, N. W., and Hines, E. A. (1946). *Peripheral Vascular Diseases*. Saunders, Philadelphia.

Medical Memoranda

Case of Erysipeloid of Rosenbach Treated with Penicillin

Infection of human beings with *Erysipelothrix rhusiopathiae* is by no means common. It is, however, to illustrate the response of this infection to penicillin therapy that the following case is described. Few cases treated with penicillin have been recorded in this country; Barber, Nellen, and Zoob (1946) reported five cases, all of which responded well to penicillin. In America three cases have been reported (Ehrlich, 1946; Ferguson *et al.*, 1947; Stiles, 1947). All these cases showed a rapid response to penicillin. The progress of the disease untreated is slow and may be anything from one to five weeks, during which time complications may arise. Other treatment is of little or no value: the organism is not sensitive to sulphonamides, and serum therapy is uncertain and often gives rise to severe reactions.

CASE REPORT

The patient, a man aged 34, is a veterinary surgeon engaged on research. Two days before attending he had been dissecting turkeys which had died of *Erysipelothrix rhusiopathiae* infections and from which the organisms had been cultured. During the dissection, not wearing gloves, he pricked himself on the left thumb. He presented with a typical lesion in that region. The skin over an area about 1 in. (2.5 cm.) in diameter was red, raised, and shiny, and the edge was sharply demarcated. Pruritus was marked and there was considerable pain and throbbing. Axillary adenitis was present, but there was no lymphangitis.