this time only a scar remained at the site of the carbuncle on his neck; the one on his thigh had completely aborted.

Case 7.—Mr. K., aged 41, had had a carbuncle on his right forearm for five days. He complained of pain up the arm and in the axilla. He was anxious to return to work as soon as possible, and 200,000 units of penicillin was given twice daily for three days, and a single dose on the fourth day. By this time the swelling had nearly subsided and the carbuncle was discharging freely.

Comment

The successful treatment of the above cases would seem to justify the use of large doses of penicillin at infrequent intervals, such as can conveniently be carried out in general practice. The particular dosage was chosen on the grounds of economy; larger doses might be even more effective and might possibly be of use in more serious conditions. In Cases 3, 6, and 7 the carbuncles cleared up in about five days and the patients were fit for work within a week; indeed, one patient continued working, though against advice, during treatment. This is an important consideration when the cost of the treatment is taken into account.

The introduction of the more highly purified white crystalline penicillin will probably greatly increase the value of this form of treatment.

Summary

Seven cases of minor conditions commonly met with in general practice, yet which had responded poorly to routine treatment, have been described. All responded strikingly to large daily injections of penicillin. In each case it was considered that there was a clear indication for this form of therapy; and in none was any local treatment given after starting penicillin therapy. It is of interest to note that the one patient who was given injections twice daily did no better than the others. In the few cases so far treated by this method no failure has been observed.

Medical Memoranda

A Case of Thrombosis of the Abdominal Aorta

The following case of thrombus formation on an atheromatous ulcer of the abdominal aorta immediately above the bifurcation of the common iliac arteries is thought worthy of record because of the disparity between the gross pathology and the symptoms produced. A remarkable feature was that in spite of a massive arterial occlusion no pain was experienced. Boyd (*Textbook of Pathology*, 4th ed., 1943) states that thrombus formation on an atheromatous ulcer of the aorta occurs much less frequently than might be expected.

CASE RECORD

A man aged 47 was admitted to the Falkirk Royal Infirmary complaining of numbness and coldness of both lower limbs of three days' duration. Seven days previously, while climbing a steep hill, he was seized with a pain in the left praecordium, extending down the left arm to the wrist, and a feeling as if his left leg was swelling and about to burst. After resting for half an hour he continued to climb the hill although the rest had not relieved the pain. On reaching the top he broke out in a cold clammy sweat and felt as if both legs were swelling to bursting point. His legs would no longer support him and he had to sit down and was later taken home in a taxi. In bed, apart from his legs and some residual precordial pain, he had no complaint. The legs were normal in colour and muscle power was normal. The next day the precordial pain and the numbness in his legs disappeared. On the third and fourth days he had no complaint whatsoever, although he remained in bed. On the fifth day he suddenly broke out in a cold clammy sweat and his right leg became numb and cold from "the sole of the foot to the hip." The leg became discoloured and muscle power was lost. *There was no pain.* Later that day his left leg from the sole of the foot to the knee became gradually numb and cold. Again pain was conspicuous by its absence. He also became incontinent of urine and faeces. Two days later he was admitted to the infirmary. On two occasions, two months previously, he had experienced slight pain in the calves of both legs on climbing a hill. This passed off quickly after rest.

On admission he was seen to be a well-built man whose face was somewhat congested and who had a fair degree of clubbing of the fingers. The right leg showed marked discoloration and was cold and pulseless. The line of demarcation was about 5 cm. below the inguinal ligament. There was complete loss of sensation and muscle power. The left leg was similarly affected immediately below the knee-joint. The heart was irregular in rhythm and force and the heart sounds were of very poor quality. The blood pressure was 110/80. Examination revealed no abnormality of any of the other systems. The Wassermann reaction was negative. He died some nine hours after admission.

Post-mortem Examination.—There was an atheromatous ulcer about 2 cm. in diameter on the anterior wall of the aorta about 4 cm. above the bifurcation of the common iliac vessels. It had involved the intima and media and was on the point of rupturing through the adventitia. There was a large adherent thrombus over the site of the ulcer, which extended down both iliac vessels to their bifurcation and involved 2 cm. of the left internal iliac. There was also a great deal of patchy calcification over the area covered by the thrombus. Proximal to this the aorta appeared normal, as did the other arteries. The heart was dilated and showed a marked fibrosis of the myocardium, the wall of the right ventricle being parchment-like. The right ventricle showed an old coronary thrombosis. An interesting feature was the complete absence of rigor mortis of the affected limbs.

I am indebted to Dr. T. Kay MacLachlan, Consultant Physician, Falkirk Royal Infirmary, for permission to publish this case.

ROBERT PAUL, M.B., Ch.B.,
Medical Registrar,
Falkirk and District Royal Infirmary.

A Case of Dissecting Aortic Aneurysm Diagnosed Clinically

In view of the infrequency of the clinical diagnosis of cases of dissecting aortic aneurysm, I am grateful for an opportunity to publish this case. Dissecting aortic aneurysms are comparatively rare lesions, and particularly so in women; the incidence in men to women is three to one (Paul White, 1946).

CASE REPORT

A well-nourished obese woman aged 40 was admitted to hospital at midnight on Jan. 24, 1947. The patient was in an acute state of shock. She was ashen grey, clammy, and perspiring; her pulse rate was about 100, irregular, and of very poor volume. It was impossible to record the blood pressure in the right arm, but the systolic pressure in the left arm was 70 mm. She was very restless, but was able to give her history fairly well. This was as follows. At 12 noon on Jan. 24, suddenly, after a very heavy morning's work, she experienced a "terrible pain" between the scapulae and radiating slightly towards the back of the neck; she fell into a chair. She vomited twice, and when seen at 2.30 p.m. the same day by her husband she was acutely shocked and "helpless"; she coughed a very small amount of bright-red blood. The only relevant past history was that she had had a cough for the last three weeks, but otherwise was well and active. She had five children alive; in the case of the youngest child, labour was induced at the seventh month for "kidney trouble and blood pressure."

Clinically it was impossible to determine the size of the heart, and the heart sounds were almost inaudible. There were no abnormal physical signs in the lungs, abdomen, or central nervous system. The fundi showed arteriosclerotic changes, and no exudates were seen. It appeared that this patient had had an acute circulatory catastrophe. Coronary thrombosis seemed a possible alternative diagnosis, but the site and nature of the pain in the back and its maximum intensity at the onset were both points in favour of a dissecting aneurysm. She died at 11 a.m. on Jan. 25.

Post-mortem Findings.—The pericardium was considerably thickened and there was a large haemopericardium. The weight of the heart was 25 oz. (0.7 kg.), and the left ventricle was hypertrophied. There was a break in continuity of the intima of the aorta in the transverse portion opposite the origin of the innominate artery; this was some 1/2 in. (1.25 cm.) long in the longitudinal direction. This break was continuous with a cavity in the wall of the aorta and dissected about one-half the circumference of the aorta. The cavity contained blood clot, and extended down to the aortic valves. The coronary arteries were fairly healthy. There was extensive atheroma of the intima of the aorta, more marked distally. The left kidney was small, with the capsule adherent, and its surface was slightly granular.

I wish to thank Dr. E. H. Brindle for permission to report the case, and Dr. J. R. Mackenzie for much helpful criticism.

RAYMOND C. GLEDHILL, M.B., Ch.B.,
House-physician, General Infirmary, Burton-on-Trent.

REFERENCE

White, Paul D. (1946). *Heart Disease*. New York: Macmillan Co.