never very intense, but it continued. Abdominal, or for that matter any, aneurysm is so rare in a woman that neither the husband nor any of his medical friends believed in my diagnosis. Eventually the patient saw by my wish an eminent London surgeon, who scoffed at the idea of an aneurysm, and promised immediate relief by removing an ovary adherent to the aorta. However, at the operation he found no such adherent ovary, but a well-marked aneurysm, and the patient has continued to suffer pain ever since.

But this case and other recorded cases did not suffer from the intense pain and restlessness displayed in our case. Dr. Gates and I thought, therefore, that we were dealing with a dissecting aneurysm, and that the separation of the coats of the aorta was the cause of the intense pain described. A dissecting aneurysm would also more probably account for a small leakage of blood into the pleural cavity, and so for the dullness found at the base of the left pleura.

Having, then, made our diagnosis, we thought we might get confirmation of it by an x-ray photograph, and Dr. Hodgson, head of the electrical department at the Royal Devon and Exeter Hospital, having a movable apparatus that he can take to patients' houses, we asked him to take a radiogram of the chest. This he did three days after the onset, and this radiogram (see Special Plate) clearly shows an aneurysm arising near the arch of the aorta.

The patient lived for nineteen days after the onset of the symptoms, being kept quiet in bed, and his pain kept in abeyance by an injection of 1/4 grain of morphine night and morning. On two occasions during this time he had severe attacks of pain with collapse, caused once by his getting out of bed against orders, and once by his getting excited about something. The temperature was at first slightly raised (99° to 100°) for four days, it was then normal for three, and then there was a rise to 101° every evening, falling to about 99° in the morning. His systolic blood pressure was at first 200 to 195, but towards the last week it varied between 162 and 159. The physical signs on the left side of the chest varied, owing to an increasing amount of fluid forming in the chest, due, as it turned out, to increasing pleuritic effusion. No bruit was to be heard over the heart or over the aorta until the day before his death, November 18th, when a well-marked humming bruit was heard over the aorta behind at the level of the fourth dorsal vertebra. On November 19th he was quiet and free from pain all the morning, but at about 4 p.m. he said he felt faint and died almost immediately. A *post-mortem* examination was performed by Dr. Solly, pathologist to the hospital, the next day, and his account is as follows:

The left pleural cavity was sealed by adhesions, and on opening this blood-stained fluid was seen, and a large amount of blood clot, mostly recent, but some of some days' standing, was removed. The heart was enlarged and showed hypertrophy, particularly of the left ventricle, but there was no valvular disease present. There was a definite dissecting aneurysm, about the size of a small orange, at the apex of the transverse arch of the aorta, caused by the rupture of the inner coat of the aorta at this situation, where it was definitely weakened by calcareous patches of atheroma. This dissecting aneurysm had ruptured into the left pleural cavity and so caused death from haemorrhage.

TRAUMATIC ARTERIO-VENOUS ANEURYSM.

BY

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[With Special Plate.]

In October, 1918, a man aged 49 fell from a bicycle, receiving a severe blow on the right side of the crown of the head. He was unconscious for several hours. A fortnight afterwards the left eye became prominent and its vision defective. Within another week the right eye began to protrude, and he was sent into Darlington Hospital by Dr. Williams of Richmond (Yorks).

On admission his appearance was as shown in Fig. 1 (see Plate). Both eyes were in a state of extreme proptosis, the conjunctivae chemosed, oozing a bloody serum and projecting in thick rolls between the lids and the corneo-scleral junction. Both corneae had lost their lustre, and their ground-glasslike surface prevented a clear view of the fundus. The pupils were slightly dilated, and vision in each eye was only 6/6. Speech was slow and the mental condition sluggish and depressed. The patient complained of a confused sensation in the head but no real headache. The temperature was normal, and there was no obvious sepsis about the nose or jaws to suggest cavernous sinus thrombosis. No pulsation could be detected about the orbits.

Suspecting arterio-venous aneurysm, I listened over the left temple and heard a loud systolic bruit. This was equally well heard over the right temple. Pressure over the left carotid tubercle silenced this bruit; pressure over the right had no effect.

The injury had evidently caused a fracture of the base of the skull, wounding the left internal carotid artery as it lay in the inner wall of the left cavernous sinus, and producing an arterio-venous aneurysm. Through the circular sinus the arterial pressure had reached eventually the right cavernous sinus, and then proptosis became bilateral.

On October 24th I tied the left common carotid, and the intracranial bruit ceased immediately. In a few days there was less oedema of the conjunctivae, and this improvement continued steadily, the proptosis diminishing *pari passu*. In three or four weeks all oedema had disappeared, and vision in the right eye had improved to 6/6. Vision in the left eye was still only 6/60, and this cornea remained "steamed." The left eye now developed an internal squint, due probably to injury of the sixth nerve by the fracture or by the subsequent arterio-venous aneurysm. As both eyes had been immobilized by oedematous surroundings this paralysis of the sixth nerve was only evident on subsidence of the swelling and return of the mobility.

Ligature of a common carotid is said to be followed by mental symptoms in some cases. In this case no ill effect resulted; on the contrary, the patient became more alert and cheerful.

One of the photographs in the special plate shows the distressing appearance of the man on admission, and the other shows the improvement three weeks after operation. The slight swelling of conjunctiva still visible above the right lower eyelid disappeared entirely during the following week. After leaving hospital the patient was lost sight of, and no information could be gathered about the final result as regards vision of the left eye and strabismus. I am informed that a year after operation he was apparently well and engaged in his usual occupation.

PNEUMOTHORAX IN A BOY AGED 7:

RECOVERY.

CLINICAL AND X-RAY REPORTS.

BY

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[With Special Plate.]

PULMONARY tuberculosis as it occurs in the adult is comparatively rarely found in children. In them thoracic tuberculosis more usually manifests itself as an enlargement of the lymphatic glands at the root of the lung, a condition which can be recognized by physical examination and by radiography. The relationship between pulmonary and glandular tuberculosis and age is not yet by any means clear, and is a very wide subject which lends itself to endless discussion. Some Continental writers, quoting the findings of hundreds of autopsies, assert that tuberculous enlargement of the glands at the root of the lung in children is always secondary to a lung focus or foci.

They describe such a focus in comparison with the adult pulmonary lesion as being usually very small, and state that often in children past infancy it is found to be in a state of arrest, cavity formation having sometimes taken place before this has come about. These foci are usually situated sub-pleurally, but on account of their relatively minute size it is not surprising that clinically, or even radiographically, their presence cannot be often demonstrated, and of course this would be all the more difficult in the case of a focus situated on the diaphragmatic or mediastinal surface. I recently came across a very interesting case of pneumothorax in a boy, aged 7, who had signs of intrathoracic glandular tuberculosis without any evident pulmonary lesion which would appear to be quite possibly an illustration of such a condition. He came under notice as a "contact" to his brother, who was already attending one of the tuberculosis dispensaries under my charge for tuberculous cervical glands, and I first examined him on February 18th, 1920.

His father had an enlarged gland removed from his neck in his youth, but since that time has not shown any evidence of tuberculosis. His mother died in childbirth; she is stated to have usually been in "poor health," for which apparently no definite cause had ever been assigned. There is no other history of tuberculosis in the family.

He was said to have attended school regularly, to be generally full of life and mischief, and rarely complained of anything except

DAVY AND GATES : CASE OF DISSECTING ANEURYSM
OF THE AORTA.

MARTIN AND KNOX : PNEUMOTHORAX IN A BOY.

FIG. 1.—Posterior.

FIG. 2.—Anterior.

ALLARDICE : FOREIGN BODIES IN THE GASTRO-INTESTINAL
TRACT IN APPENDICITIS.

Skigram taken after first operation, showing fork, hairpins, etc., still
in the abdomen.

FARQUHAR : TRAUMATIC ARTERIO-VEINOUS ANEURYSM.

FIG. 1.—Showing appearance of the
patient on admission to hospital.

FIG. 2.—Showing improvement three
weeks after operation.