question might form a fitting subject for collective investigation. It is at present merely interesting—possibly, in some aspects, also humorous.

REFERENCE.

¹ Ainley Walker and J. H. Ryffel, BRITISH MEDICAL JOURNAL, September 19th, 1903.

ANEURYSM OF THE HEART DUE TO SYPHILITIC GUMMATA.

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[Communicated by the Director-General, R.N.]

THE number of cases recorded of true sacculated aneurysms of the heart are so few that I have thought this one of sufficient interest to report.

The patient was a plethoric though apparently healthy man, aged 34, who was actively employed in the canteen at his barracks. Beyond a few periods of temporary disablement from traumatism there was no entry of interest in his medical record except that he had suffered from secondary syphilis in 1900.

Death occurred quite suddenly while at duty.

At the *post-mortem* examination the pericardium contained a quantity of fresh blood clot and serum; the heart was rather large. On opening the left ventricle the surface of the endocardium below the semilunar valve showed an irregular mottled cicatrized appearance over an area the size of a three-penny piece, and exactly opposite to it, by the mitral cusp, was a dense white patch of endocardium. The section of the heart wall below the auricular-ventricular ring showed marked evidence of myocarditis with fibroid degeneration.

Externally, below the left auricular appendix, was a definite globular aneurysm, the size of a small

tangerine orange, having an opening from the left ventricle large enough to admit the tip of the little finger. The wall of the aneurysm became thinner as its distance from the ventricle increased, at the site of the rupture being like thin paper. There was no laminated clot in the interior.

The aorta showed numerous atheromatous patches, and the coronary arteries were rigid but not occluded. A microscopical examination of the diseased heart wall showed a decrease of muscle fibres, with a marked small-celled infiltration and sclerosis of the small vessels.

There is little doubt that the aneurysm was due to degenerative changes in the myocardium following gummatous infiltration, "a true sequela of syphilis."

Osler states that aneurysms of the heart are due to acute or chronic myocarditis, gumma of ventricle, or traumatism, and that the apex of the left ventricle is the most common seat (59 out of 60 cases, Legg). Dr. Wickham Legg attributes these aneurysms to fibrous degeneration of the heart muscles, which is commonly due to impaired coronary circulation, but adds that many cases of aneurysms of the heart are found in people under 40 in

whom the coronary arteries show no change, so that he doubts whether coronary obstruction is responsible for the myocarditis in all cases.

Sir Samuel Wilks first drew attention to the occurrence of syphilitic lesions of the myocardium in 1856. These may be due to:

1. Syphilitic arteritis, and secondary or combined chronic myocarditis.
2. Gummatous formation in the heart wall causing chronic myocarditis.
3. Diffuse chronic myocarditis due to scattered gummatous deposits.

These gummatous formations occurring most commonly in the ventricular walls and in the septum.

As to the relative frequency of cardiac aneurysms,

Legg records 3 cases in 1,890 *post-mortem* examinations, Heschl had a proportion of 1 in 200, and Willigh 1 in 177. From an examination of the records of the last 300 *post-mortem* examinations made at Haslar I find that death was due to aneurysm of the large vessels in 25. In 2 there was an aneurysm of the heart itself: The present case, a sacculated aneurysm of the left ventricle due to syphilitic degeneration of the heart wall; the other an aneurysm at the apex of the left ventricle in an old pensioner, due to extensive thrombosis of the left coronary artery.

The fact that so large a proportion of men in the naval service have been subjects of secondary syphilis undoubtedly predisposes them to these aneurysmal lesions.

Aneurysm at base of left ventricle, rupture. Endocarditis and myocarditis due to gummata in wall. A, Atheroma of aorta. B, Fibroid patch in wall of left ventricle. C, Endocardial patch. D, Left auricular appendix. E, Fibroid patch in ventricular wall. F, Aneurysm. G, Site of rupture. H, Entrance of aneurysm. I, White thickened endocardium by mitral valve.

A SOCIETY for the study of beri-beri has been formed at Tokyo. The President is the Chief of the Medical Department of the Japanese Army. The society aims at discovering an effectual means of stamping out the disease.

DR. VERA DAUTSCHAKOFF was recently licensed as a private lecturer in histology by the Medical Faculty of Moscow. The appointment has been vetoed by the Russian Minister of Public Instruction on the ground that, as the law does not give women the right to study in universities, *a fortiori* they cannot be allowed to teach. He has further ordered that no licences of the kind be granted in future.

At a meeting of the General Purposes Committee of the Metropolitan Hospital Sunday Fund on October 17th it was announced that the subscriptions for the year would reach £80,000. The gross sum thus exceeds that received last year by some £1,500. It is to be noted, however, that it includes some £35,000 received as interest on the estate of the late Mr. George Herring; and it was reported that there had been a serious falling off in the amounts received from collections at places of worship.