SYMPHYSIS OF THE SPLEEN WITH THE LIVER: SPONTANEOUS RUPTURE OF THE RIGHT VENTRICLE AND SYPHILITIC AORTITIS.

BY

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I ONCE examined a boy with considerable splenomegaly of uncertain nature in whom abdominal palpation suggested that the spleen might be closely adherent to the left lobe of the liver. In that case, which cannot be discussed here, one physician recommended splenectomy (there had been an attack of haematemesis and melaena), and indeed the possibility of real symphysis of the spleen with the liver was hardly entertained as possible. Such a condition of real symphysis, whether congenital or acquired, must be one of extreme rarity, and I never met with a certain example until recently at the post-mortem examination on a man, whose case was likewise noteworthy for other reasons.

The patient was a powerfully built man, aged 50, who for some years past had been ailing with oedema of the feet and dyspnoea on exertion. In the hospital the heart was much enlarged and there were typical signs of aortic reflux. The urine contained a trace of albumin and some hyaline and granular tube-casts. The brachial blood pressure (April 22nd, 1929) was 150 mm. Hg (systolic) and 40 mm. Hg (diastolic). There was some serous effusion in the right pleura. A blood count showed slight anaemia (3,760,000 erythrocytes and 11,100 white cells in the cubic millimetre of blood). He had never had rheumatic fever. On May 18th his temperature was 100.4° F., and there was evidently, as there had been of late, a feeling of thoracic pain or discomfort of some kind. About 8 a.m. he asked for drink, said he felt better after drinking, but became suddenly cyanosed and died in two minutes.

The necropsy (carried out by the house-physician, Dr. Scholtz, on the same day in my presence) showed right-sided serous pleural effusion and slight ascites. The pericardium contained about 100 c.cm. of blood and serum, and through a minute slit-like rupture, about one centimetre in length, in the anterior wall of the right ventricle (close to and parallel to the anterior interventricular groove, five centimetres from the apex), blood could be forced out in a fine jet on squeezing the heart. There was great hypertrophy of the left ventricle, and the enormous heart weighed 800 grams. The aortic cusps themselves were only slightly sclerosed, but the first part of the aorta was a little dilated and much thickened and sclerosed. Microscopically the aortic wall showed patchy small round-cell infiltration, chiefly of the middle and adventitial coats, certainly a result of syphilitic aortitis. Dr. J. G. Greenfield, who kindly looked at a section with me, pointed out that nearly all the infiltrating cells were characteristic plasma cells. The rupture had taken place between the columnae carneae at a spot where the muscle was only two millimetres in thickness. On microscopical examination of that region many of the muscular fibres were obviously atrophic.

The kidneys were rather large and together weighed 550 grams. Though the capsules stripped readily, the cortex of one of them had a slightly granular surface.

The spleen (about twice the size of the normal) was so adherent to the left lobe of the liver that at first sight it appeared to constitute an abnormal additional hepatic lobe. The area of the fibrous adhesion (symphysis) was larger than the palm of a large hand. The two organs together weighed 2,100 grams, and showed chronic congestion. Microscopical examination of the thin layer of fibrous tissue uniting the two organs showed little evidence of inflammation. Nevertheless, there were some perihepatic and other chronic peritonitic adhesions present, and perhaps one cannot be absolutely certain that the symphysis of the spleen to the liver was congenital.

The specimens are now in the museum of the Royal College of Surgeons, London, and I am much indebted to Mr. T. W. P. Lawrence for assistance in examining them.

Mr. D. M. Greig, conservator of the museum of the

Royal College of Surgeons at Edinburgh, has kindly drawn my attention to a report by De la Torre (*Presse médicale*, Paris, 1926, xxxiv, p. 669) on the case of a woman, aged 24 years, in whom a "tongue" of hepatic tissue about 70 mm. in breadth was connected with the uterus. The "tumour" was recognized by palpation, but operation was refused. A few months later she married, and, when eight months pregnant, the arch of hepatic tissue between the liver and uterus caused intestinal obstruction and the condition was discovered at operation. Mr. Greig observes that if an abnormally shaped liver can become adherent to the uterus there is no reason why a liver in the left hypochondrium should not become adherent to the spleen. Mr. Greig in this connexion mentions that Abernethy (*Philosophical Transactions*, London, 1793, lxxxiii, p. 59) reported the case of a female child, aged 10 months, in whom the liver extended equally into the right and left hypochondria. In that case, Mr. Greig adds, the extension of the liver to the left may perhaps have been etiologically connected with the fact that the child's spleen consisted of seven separate portions, to each of which a branch of the splenic artery passed.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

HEADACHES OF PERIPHERAL ORIGIN.

OUR increasing knowledge of the numerous close connexions which exist between the periphery and centrally placed organs has helped us in recent years to understand the causes of this type of headache. It will suffice merely to mention the great clinical importance of Head's zones. I wish, however, to draw attention here to the connexion which exists between some infiltrations of the nape of the neck and headaches which may have persisted for years (sometimes dating from childhood) and from which the patient is rarely free for a day or a week at a time.

These infiltrations may sometimes be recognized by inspection, if the nape and other parts of the neck are carefully examined. (It is very important that the head should be held symmetrically for this purpose, as even a slight deviation may easily simulate pathological differences between the two sides.) By careful inspection very slight differences between the right and the left side may be observed, corresponding to differences in consistency which may be palpable. The three middle fingers are passed gently from above downwards, first on one side and then on the other, avoiding deep pressure to begin with. By this means it is possible to detect small differences in the consistency of the tissues on the two sides. In order to estimate with greater accuracy how deep these differences lie the pressure is gradually increased, care being taken to avoid too much force, as this would interfere with the sense of touch. Palpation is thus gradually extended to deeper parts.

When the whole neck has thus been palpated it is common to find here and there a smaller or larger infiltrated area of which the patient may be quite unaware, and which, curiously enough, does not always appear to be tender on pressure. These infiltrations are always diffuse; they are not circumscribed as "points" or "nodules"; they may be as large as the palm of a child's hand, and as regards depth may lie in the skin or subcutaneous tissue or extend through the muscles down to the bone.

The headaches, of which the patients may have complained for years, are not generally uniform in type. The patients suffer from attacks almost daily or at intervals of a few days; it is characteristic of this type of headache that it occurs in the morning on waking. The degree of pain also varies considerably: it is sometimes merely very unpleasant and at another time it may be very severe. It is noteworthy that only a proportion of the patients complain of a definite association of the headache with bad weather.

I consider the connexion between the above-mentioned infiltrations and rheumatism to be as follows. By careful examination it is generally possible to demonstrate a more or less intensive focal infection in the tonsils, teeth, pharynx, nose, or accessory sinuses. From these foci dead