

syphilitic nature in most of his material. The occurrence of genuine gummata in the aorta he considers doubtful, as the necrosis attacked, not the granulomatous tissue, but only part of the aortic wall.⁴ However, in our case the localized infiltrations with giant cells show plainly, not only necrosis of the aortic wall, but a similar tendency on the part of the granuloma cells, and therefore present the features of the typical gumma. (Fig. 4.)

Mönckeberg and Ziegler and others refer a number of the cases of mesaortitis, not to syphilis, but to coccal infection. It must be admitted that in certain, especially late cases, it is impossible to form a definite opinion. For, when a process has gone on to scar formation or when the mesaortitis is more diffuse without characteristic gummatous formations, one cannot decide whether it results from a syphilitic or other infection. A similar difficulty applies to cases associated with advanced arteriosclerosis. For these reasons I regard the case here presented as valuable because it conforms in location, morphological evidence with history, the absence of a complicating arteriosclerosis, and the certainty of excluding tuberculosis, with the picture of true gummatous aortitis, a mesaortitis gummosa.

A practical point of interest is one to which Heller drew attention, the great importance which must be attributed to syphilis in the production of aneurysms and perforations of vessels, on account of its distinct, destructive tendency in the media and adventitia. This, as very much greater than in arteriosclerosis, makes the granulomatous aortitis of much greater danger than the uncomplicated arteriosclerosis.

Clinically the case is interesting, to observe how extensive lesions may occur in the aorta and progress to fatal termination without manifesting symp-

⁴Herxheimer, Zur Aetiologie und pathologischen Anatomie der Syphilis in *Ergebnisse der allgemeinen Pathologie und pathologischen Anatomie*, xi, 1, 1907.