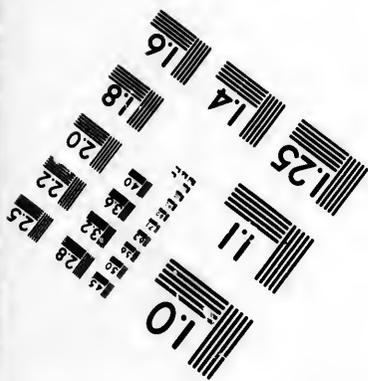
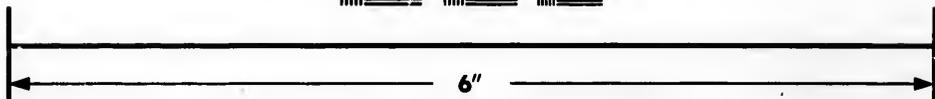
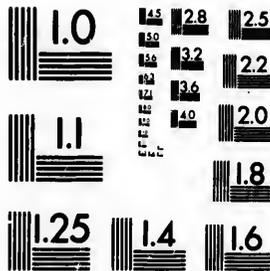


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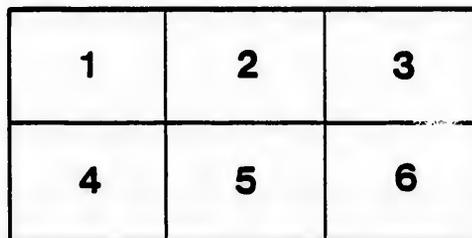
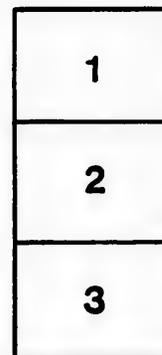
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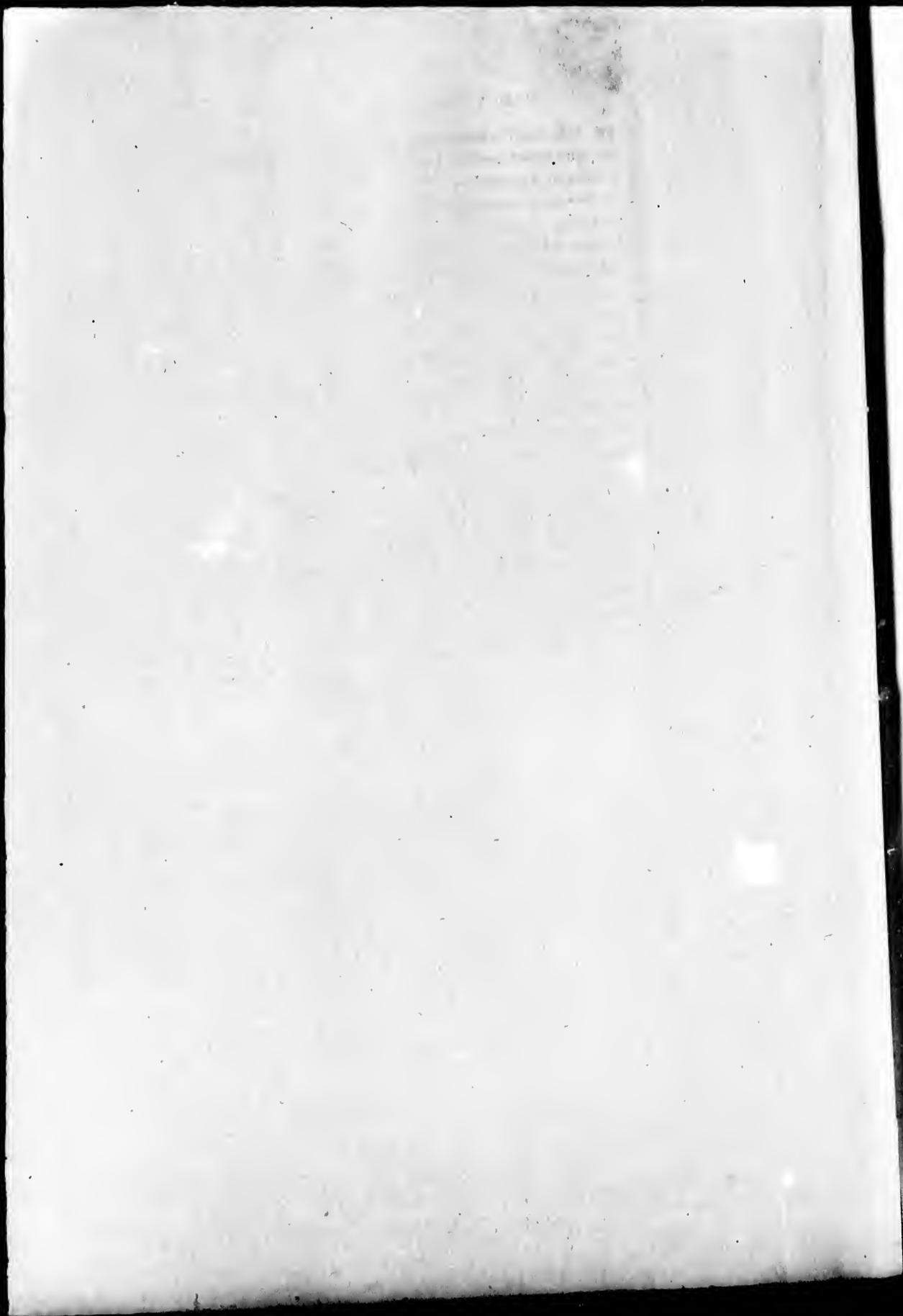
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THE FURTHER HISTORY OF A CASE OF ANEURISM OF THE  
THORACIC AORTA OF UNUSUALLY LARGE SIZE, ATTENDED  
WITH LOCALIZED UNILATERAL SWELLING.

BY R. L. MACDONNELL, B.A., M.D.,

PROFESSOR OF CLINICAL MEDICINE IN MCGILL UNIVERSITY; PHYSICIAN TO THE MONTREAL  
GENERAL HOSPITAL.

In this JOURNAL for March, 1888, I reported a case of aneurism of the thoracic aorta, in which sweating over a limited area of the chest wall had been repeatedly observed. At the time of the publication of that report the patient was in very good condition and had left the Montreal General Hospital, where he had spent the winter of 1885-86, and had gone to resume his occupation as the proprietor of a small eating house. The relief to the symptoms and the manifest diminution in the force of the pulsations in the area between the scapule where the tumor reached the chest-walls was attributed to the persistent use of the iodide of potassium.

The case has been under my observation for the last four years, though an interval of a year (1888-89) elapsed without my having seen him.

In the winter of 1887-88 he was in fair health and there was no increase in the area of percussion dulness in the left inter-scapular region, but he had lost weight to a considerable extent. There was no more dyspnea, and he could sleep with comfort when lying down. There was very little cough.

During the last winter (1889-90) he began to suffer from paroxysms of coughing and from very severe pains in the chest. On November 21, 1889, I made a careful physical examination, comparing every point with the report already published in THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES. He had been taking the iodide of potassium in ten-grain doses twice daily for four years. The pulse at both wrists was equal, but it had entirely lost its collapsing character and there was no longer any visible pulsation in the vessels of the neck. There was no perceptible bulging in the upper part of the chest. The systolic murmur, which was audible four years previously at the back of the chest, was no longer perceptible. There was absolute silence at the base of the left lung up to within two inches of the angle of the scapula.

During the month of November, 1889, the pulsation in the back was so feebly marked that, in order to demonstrate its existence to the students of my clinical class, I had to resort to the device of gumming upright slips of paper to the skin to render more evident the movements of the surface. But, as the winter advanced, there was a great increase in the thoracic pain, and the patient began to experience the semi-

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anginal attacks previously described. At this time he reported to me a recurrence of the sweating in the left side of the chest, which he had noticed for the first time since he had left the hospital in 1886. The whole of his brown skin was very dry, except over the area in the left chest corresponding to the neighborhood of the fifth and sixth ribs. This limited area could be seen and felt to be moist, while the skin on the corresponding area on the other side was quite dry. Closer observation convinced me that this moisture appeared whenever the pain became severe, and that when the patient was comfortable and free from pain the skin of the left chest was perfectly dry.

In December, 1889, the patient entered the hospital for the last time. There was then great pain on movement and great muscular weakness. The sweating on the chest was distinctly visible for a few days after admission. Owing to the great pain on movement a complete examination of the chest was not practicable. After some days the pain diminished and it became no longer necessary to administer morphine. The sweating never reappeared. A great change was observed in the area of pulsation. On the 30th of December, after he had been in the hospital a week, this area was found to be extending. Formerly it might have been covered by a circle two inches in diameter, but now it measured 7 x 4 inches, and the pulsation was comparatively very forcible.



During the following fortnight there was much less suffering. A remarkable change took place in the back. The pulsating area now became prominent and protruded a good two inches from the general

level of the surface extending from just below the vertebra prominens to the lumbar region and filling up the space between the midline and the angles of the ribs. In outline the tumor had the shape of a large sausage and appeared to lie just beneath the skin, and it measured eleven inches from above downward, and four inches from side to side. It was universally pulsatile and felt as if there was very little tissue between the skin and the pulsating body. No thrill or bruit perceptible. There was comparative relief from pain coincident with the rapid outgrowth of the tumor. A fortnight later and the tumor measured 13 x 5 inches. The vertebral column does not appear to have been encroached upon, but the growth seems to have taken place in the direction of the angles of the ribs. Death took place on February 4, 1890, apparently by exhaustion. Most unfortunately the relatives objected to an autopsy.

The photograph reproduced in connection with this paper was taken instantaneously, and shows the appearance presented by the aneurism about a week before death. It is possible that the recent rapid development of the tumor may have been the result, not of steady growth of the main sac, but of the formation of a false sac by rupture of the original one, and by the extension of the blood thus extravasated to the tissues.

The case is of interest as showing the presence of a new symptom and the benefits of the iodide of potassium treatment. The enormous size to which a thoracic aneurism may attain without destroying life, is also well illustrated.

