thrombosis. Bone marrow showed increased number of megakaryocytes – some normal with normal platelets, others showed a hyaline cytoplasm, often with vacuoles and devoid of platelets. This was suggestive of subacute or chronic idiopathic thrombocytopenic purpura.

The association of low platelets with massive intravascular thrombosis has been described before, but these cases also have increased coagulability of blood. We considered in this case the consumption of platelets to be one of the factors. He never developed purpura, hypertension or high blood urea, and thrombotic thrombocytopenic purpura is thus excluded.

In the presence of these features, we considered this to be a diffuse vasculitis and treated him with prednisolone to which he responded well. His eyes recovered but he continues to have superficial and deep femoral thromboses.

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Cerebral Emboli from Aneurysm of Left Atrial Appendage

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S A, boy born 15.12.60

History: November 1961, sudden onset transient weakness of right arm; fifteen generalized convulsions during next two days, each lasting one minute, preceded by fifteen minutes of unusual quietness.

On examination: Pyrexial. 'Dreamy and far away'. No other abnormalities.

Investigations: CSF, skull X-ray and ECG normal. Chest X-ray showed globular enlargement of left cardiac border (Fig 1).

Progress: No further fits. Mental state normal and apyrexial within two days. Provisional diagnosis: 'viral encephalitis'. September 1962: Left-sided convulsive movements with development of coma for one day and left hemiplegia which improved over three days. Two weeks later, similar episode affecting right side and resulting in dysphasia, dysarthria, dysphagia and right hemiplegia which have persisted ever since.

Chest X-ray unchanged. Diagnosis of cerebral emboli considered. Angiography suggested lesion involving left ventricle.

Subsequent treatment: December 1962–November 1966: Anticoagulant therapy with phenindione. No further cerebral incidents occurred. Physiotherapy and speech therapy. November 1966:

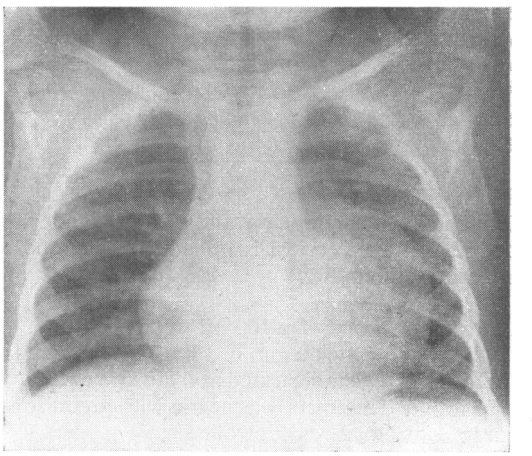

Fig 1 *Chest X-ray, November 1961, showing globular enlargement of left cardiac border*

Excision of aneurysm of left atrial appendage (Mr E Aberdeen). Anticoagulants discontinued post-operatively. May 1968: Palatopharyngoplasty (Mr J Watson, East Grinstead).

Comment

There are three main features of interest:

The cerebral incidents in retrospect were compatible with emboli arising directly from the aneurysm of the left atrial appendage.

Nature of the cardiac lesion: Aneurysms of the left atrium are uncommon except in association with mitral valve disease. Taussig (1960) mentions a case but the appendage was not involved. Three children with aneurysms of the left atrial appendage were reported (Parmley 1962, Pitts & Potts 1962); the X-rays were all similar to the present case; one had cerebral and other emboli.

Thoracotomy was postponed in S A because of the hazards. Anticoagulant therapy successfully prevented further embolic episodes. At operation the aneurysm contained no clot (clots were found in 2 of the other reported cases).

Eight adult cases have been reported (Williams 1963, Godwin *et al.* 1968), 2 with cerebral emboli.

The speech defect in S A has two components: executive dysphasia, and dysarthria. The former (and his hemiplegia) has improved steadily. The dysarthria remains severe. This and the residual dysphagia (with drooling) are expressions of a suprabulbar palsy due to multiple emboli.

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