

tibial muscles but also had atrophied sternomastoids, paresis of frontalis and orbicularis muscles, and a wasted tongue. It is quite probable, therefore, that that case may have been an unusual type of dystrophia myotonica. The predominance of involvement of the leg muscles in the present case indicates that it is an example of distal myopathy. In view of the electrical abnormalities found in the peronei muscles, and the "inverted champagne bottle" appearance of the lower limbs, the diagnosis of Charcot-Marie-Tooth syndrome was excluded by the absence of any sensory changes and by the normal upper limbs.

An interesting point in the above case was the presence of slight spasticity and hyperreflexia in the lower limbs. In most cases of muscular dystrophy the tendon jerks are reduced or lost *pari passu* with the muscle-wasting. A number of cases have, however, been recorded in which muscular dystrophy was associated with spasticity in Friedreich's ataxia (Bramwell, 1893; Hodge, 1897; Rook and Dana, 1890). There was in this case, however, no evidence of cerebellar ataxia or of any of the commonly found features of Friedreich's disease. Creatinuria is a common finding in muscular dystrophy, and is found even on a creatine-free diet (Boothby, 1932). It is often associated with a diminished urinary excretion of creatinine. These findings have been attributed to the loss of muscle tissue occurring in the disease. This patient's urine showed an increased creatine excretion, but the amount of creatinine present in the urine was within normal limits. Bony changes of rarefaction and increased fragility have been described in muscular dystrophy by Spiller (1905a, 1905b) and Merle and Raulot-Lapointe (1909), but these were not evident in this case.

My grateful thanks are due to Major-General R. Priest for his valuable criticism and advice on this case report.

GERALD SANDLER, M.B., B.S.,

Captain, R.A.M.C.; Medical Division, Military Hospital, Colchester.

REFERENCES

- Boothby, W. M. (1932). *Proc. Mayo Clin.*, 7, 557, 737.
 Bramwell, B. (1893). *Atlas of Clinical Medicine*, vol. 2. Edinburgh.
 Gowers, W. R. (1902). *British Medical Journal*, 2, 89.
 Hodge, G. (1897). *Ibid.*, 1, 1405.
 Merle, P., and Raulot-Lapointe (1909). *N. Iconogr. Saltét.*, 22, 229.
 Rook, C. W., and Dana, C. L. (1890). *J. nerv. ment. Dis.*, 17, 173.
 Spiller, W. G. (1905a). *Rev. Neurol. Psychiat.*, 3, 388.
 — (1905b). *Univ. Penn. med. Bull.*, 17, 342.

Desmoid Tumour Resembling a Pseudo-Pancreatic Cyst in a Male

A man aged 40 was first examined on March 27, 1954, when he was complaining of swelling of the upper abdomen with discomfort and nausea for a month. Two months previously he had been hit in the epigastrium by a small child, but there was no history of major trauma or any surgical scars. The upper abdomen contained a palpable mass which extended down to the umbilicus. This mass was hard and smooth. His general condition was very good. Barium-meal examination showed pressure on the stomach from below and a greatly widened duodenal loop (Fig. 1). Various pathological tests were normal.

On April 2, under general anaesthesia (Dr. T. Lamrock), a biopsy was performed, and the tumour, which was infiltrating the posterior rectus sheath and rectus muscle for at least 15 cm. of its length, was found to be firm, pink, very vascular, and filling the upper half of the abdomen. Macroscopically the tumour resembled an invasive, rapidly growing sarcoma. The microscopical appearances of the sections were similar to those of a desmoid tumour. The tumour had not extended through the anterior rectus sheath, but the overlying subcutaneous tissues contained numerous very dilated veins. There was no increased peritoneal fluid, and, as was to be expected, there was no indication of metastases.

On June 4, under general anaesthesia (Dr. J. Bowen) and through an inverted T incision, the old wound, the tumour, the upper half of each rectus muscle with its sheath, the adjacent peritoneum, and adherent omentum were all removed *en*

bloc. The gap in the abdominal wall (23 cm. long, 5 cm. wide at the upper end, and 13 cm. wide at the lower end) was covered with tantalum gauze. The skin was then closed and the wound drained. Convalescence was uneventful.

The excised tumour (Fig. 2) was encapsulated on its deeper aspect and measured 30 by 24 by 10 cm., with a portion of the rectus sheath and muscles 23 cm. long attached. The tumour had a fairly tough greyish-pink cut surface with coarser fibrous bands in places, and weighed 11 lb. 14 oz. (5.3 kg.). Microscopical examination showed rather vascular loose fibro-cellular tissue. The nuclei were small and uniform and mitoses were difficult to find. The appearances were consistent with a diagnosis of desmoid tumour.

Since then there has been no indication of an incisional hernia or of any recurrence of the tumour.

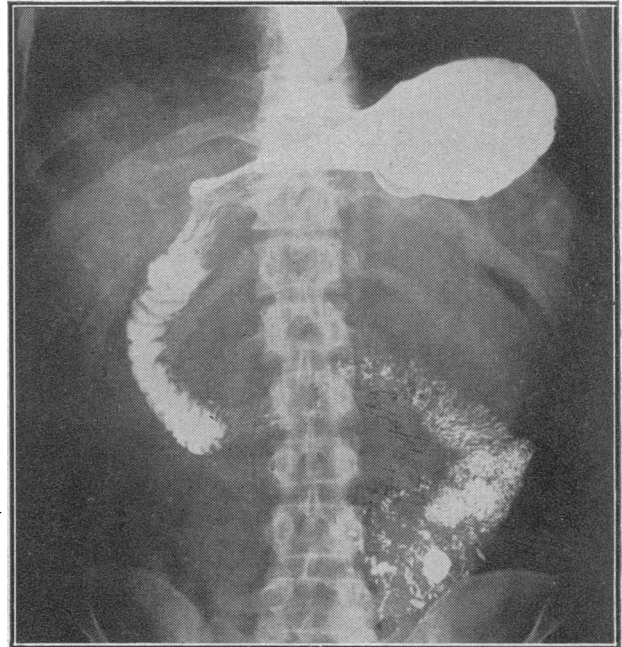


Fig. 1.—Barium-meal examination showing that the stomach was displaced upwards and that the duodenal loop was considerably widened.

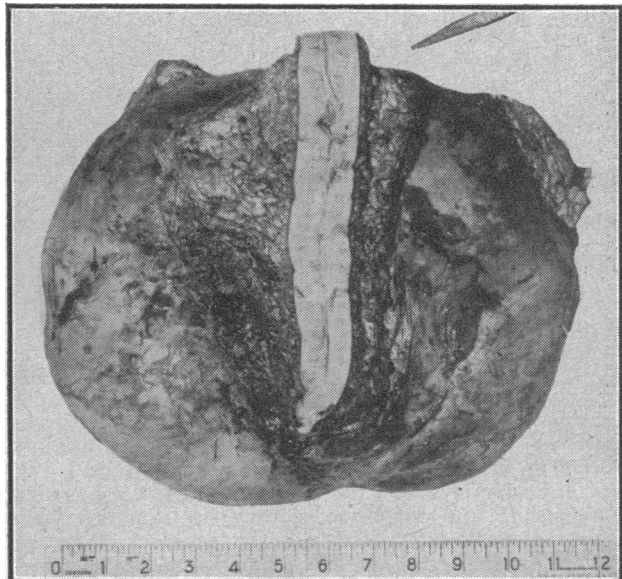


Fig. 2.—Anterior aspect of the tumour showing the adherent strip of skin and rectus muscle. The scale is in inches.

COMMENT

Desmoid tumours are not common and may present difficulties in diagnosis, especially when occurring in males or in situations other than the anterior abdominal wall. In this case the tumour projected posteriorly into the abdominal cavity and prior to operation appeared to be a pseudo-pancreatic cyst. When exposed at operation the macroscopic appearances of the tumour resembled those of a rapidly growing malignant neoplasm.

Wide removal of a desmoid tumour is imperative if recurrence is to be prevented (Strode, 1954), but after such removal the magnitude of the gap in the abdominal musculature and peritoneum may be so great as to preclude any attempt at simple closure. In this case the underlying gap was bridged with a piece of tantalum gauze which overlapped the aponeurosis by at least 3 cm. all round. This gauze was fixed in position with numerous cotton sutures. Although the tantalum was left in direct contact with the stomach, bowel, and omentum, no evidence of any adverse reaction to this has been noticed. The skin of the abdominal wall had not been involved by the tumour, and thus there was no problem with its closure.

Other materials available for closing such a gap in the abdominal musculature include fascia lata, skin, polyvinyl sponge (Schofield *et al.*, 1954), and steel mesh (Burnell, 1951); but no material could have been any more effective to date than the tantalum gauze has been here. The abdominal wall is firm and the patient is free of symptoms despite resumption of his usual activities as a general practitioner.

Although Touroff (1954) has suggested phrenicectomy to reduce tension in such a wound until it becomes firm, this manoeuvre was not employed, as it is considered that lateral tension on the wound may be reduced sufficiently by bands of adhesive plaster encircling the body. Such encircling bands have previously been used in many cases of repair of extensive incisional herniae without deleterious effects, and were also used in this case.

EDWARD WILSON, M.D., M.S., M.Sc., F.R.C.S.,
Sydney, Australia. F.R.C.S.Ed., F.R.A.C.S., F.A.C.S.

REFERENCES

- Burnell, G. H. (1951). *Aust. N.Z. J. Surg.*, 20, 232.
Schofield, T. L., Hallenbeck, G. A., Grindlay, J. H., and Blades, E. J. (1954). *Arch. Surg. (Chicago)*, 68, 191.
Strode, J. E. (1954). *Ann. Surg.*, 139, 335.
Touroff, A. S. W. (1954). *J. Amer. med. Ass.*, 154, 330.

Aneurysm of the Pulmonary Artery Resulting from a Chronic Pulmonary Embolus

The following case is an example of chronic cor pulmonale developing as a result of pulmonary embolism, and we feel that it is of interest because of its rarity and because of the time that elapsed between the original embolism and death.

CASE HISTORY

The patient, a spinster, was born in 1902. She was admitted to hospital on February 28, 1945, suffering from a paranoid psychosis. A frontal leucotomy was performed in January, 1947, operation and convalescence being uneventful. Her mental state did not improve very much, but she was active and industrious.

In March, 1950, she was seen to be limping and was found to have a thrombosis of the left femoral vein. This was treated with paravertebral injection of procaine hydrochloride and support with an elastic stocking, and the symptoms and signs subsided. In January, 1953, thrombophlebitis of the left femoral vein was diagnosed, and on one occasion she complained of tightness of the chest and unproductive cough. The oedema of the leg subsided and she again became ambulant, continuing to wear an elastic support. In December she was noticed to be dyspnoeic on exertion and slightly cyanosed, and in February, 1954,

oedema of both ankles developed. In April she had one attack of vomiting and became gradually more dyspnoeic. X-ray examination of the chest in July showed an aneurysmal dilatation of the left pulmonary artery. She now presented clinically as a case of chronic cor pulmonale, and a second x-ray examination in November showed further cardiac enlargement. In January, 1955, she collapsed and died.

Post-mortem Findings.—The body was that of a well-nourished middle-aged woman. The face and extremities were intensely cyanosed and both legs were oedematous to the thighs. The trachea and larynx were congested, and the lungs, though showing fibrotic changes throughout, did not contain any areas of infarction. Very marked hypertrophy and dilatation of the right ventricle and a small patent foramen ovale were found. There was a large embolus at the bifurcation of the pulmonary artery extending into both main branches and almost completely occluding the left. The clot was organized and organizing, largely endothelialized on the inner surface. It had clearly been *in situ* for some time, long enough for hypertrophy of the right ventricle to occur. Apart from a little atheroma there was no underlying disease of the vessel. The liver and spleen showed chronic congestion and the spleen showed scars of old infarcts. The left femoral and popliteal veins were thickened and fibrosed, with obstructed lumen, the result of past thrombosis and partial recanalization.

COMMENT

The almost complete occlusion of the first part of the left pulmonary artery by clot and the resultant dilatation behind the stricture gave rise to a striking radiological appearance suggestive of aneurysm. Aneurysms of the pulmonary artery are uncommon lesions, though simple dilatation may occur in mitral stenosis (Watkins and Harper, 1954). Brenner classifies the causes as traumatic, mycotic, congenital, and syphilitic. Others consider atheroma to be a significant aetiological finding.

Clifford *et al.* (1950) described a case of aneurysm of the pulmonary artery due to multiple emboli, and Boucher *et al.* (1951) reported a case due to embolism and diagnosed radiologically.

Our thanks are due to Dr. E. P. H. Charlton for permission to publish this case report.

R. FRANKLIN, M.B., Ch.B.,
A. C. P. RITCHIE, M.R.C.S.,
Banstead Hospital, Sutton, Surrey.

REFERENCES

- Boucher, H., Protar, M., and Bertein, J. (1951). *Ann. Méd.*, 52, 803.
Clifford, W. J., MacGillivray, L. F., and Goodale, R. H. (1950). *Amer. J. Roentgenol.*, 64, 414.
Watkins, D. H., and Harper, F. R. (1954). *Amer. Surg.*, 20, 602.

Several new Italian journals dealing with medicine and its allied sciences have been announced recently. *Minerva Fisioterapica*, a quarterly journal devoted to physical therapy and nuclear medicine, is an addition to the series published by Edizioni Minerva Medica, 83, Corso Bramante, Turin. Annual subscription is 3,000 lire. *Il Bassini*, a quarterly journal from the Pio Istituto Bassini, 1, Via Recordi, Milan, contains clinical and biological papers, preferably of surgical interest. Annual subscription is 1,000 lire. *Anatomia e Chirurgia*, another quarterly journal, contains papers on surgery with special reference to its anatomical relations. It is published from 1a, Via Palestro, Rome, 305 (annual subscription 4,000 lire). *Archives Italiennes de Biologie*, founded in 1882 by Angelo Mosso and suspended in 1935, is to recommence publication in 1957 under the editorship of Professor G. Moruzzi, Pisa. Its past volumes contain many important contributions from Mosso, Bizzozzero, Golgi, Grassi, Luciani, and other eminent figures in Italian medical science. It will publish original work on physiology, in either French or English. Annual subscription \$10 (Sala delle Stagione, 1, Lungarno Paccinotti, Pisa).