


The searching into the works of Nature, while it delights and inlarges the mind, and strikes us with the strongest assurance of the wisdom and power of the divine Architect, in framing for us so beautiful and well regulated a world, it does at the same time convince us of his constant benevolence and goodness towards us.—Statistical Essays. REVEREND STEPHEN HALES. From the Dedication to His Royal Highness, George, Prince of Wales. Volume I, The Second Edition, London, 1731.


Each case has its lesson—a lesson that may be, but is not always, learnt, for clinical wisdom is not the equivalent of experience. A man who may have seen 500 cases of pneumonia may not have the understanding of the disease which comes with an intelligent study of a score of cases, so different are knowledge and wisdom, which as the poet truly says, 'far from being one, have oft-times no connexion.—Aequanimitas and Other Addresses. Blakiston & Co., Philadelphia, and T. K. Lewis, London, 1904.
BIOSYNTHESIS OF EPINEPHRINE AND NOREPINEPHRINE


The 8 patients described in this paper have 3 features in common: all of them developed shock in the terminal phases of their illnesses, all 8 were treated vigorously with levarterenol (Levophed), and diffuse damage involving the proximal tubules associated with changes in the glomeruli and blood vessels were present. These lesions in the kidney are similar to the "proximal tubular necrosis" with "focal cortical necrosis" described by Sheehan and Moore and attributed by them to vasospasm. It is therefore suggested that the postmortem findings with respect to the kidneys, in the 8 patients described in this report, are the result of severe ischemia due to spasm of the renal arterioles and the medullary veins. The cause of the spasm is believed to be shock which was intensified and prolonged by the therapy with levarterenol.

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pression del bronco sinistre per un grande dilatation aneurysmic del arteria pulmonar. Le revista del litteratura non produceva ulle simile caso.

REFERENCES


Brit. M. J. 1: 1278 (June 1), 1957.

A simple safe test for the detection of atrial septal defects which is of value in the symptomless patient is described. This test is based upon the rise in the right atrial pressure above the resting level that occurs immediately after performance of the Valsalva maneuver. With an atrial septal defect or a patent foramen ovale the sudden rise in net right atrial pressure during the first few seconds after the end of the Valsalva maneuver causes a right-to-left pressure gradient across the defect with desaturated blood going into the left atrium. The resulting change in arterial oxygen saturation may be detected by the ear oxymeter method. In 32 patients with suspected atrial septal defects study by means of this test proved to be of value. In 12 in whom the diagnosis was proved by cardiac catheterization or thoracotomy, characteristic and reproducible changes in arterial oxygen saturation were found. In 14 further patients with positive oxymeter responses to the Valsalva test, there was catheter evidence of a left-to-right shunt at the atrial level but definite anatomic proof of an atrial septal defect was lacking. Five patients had a negative response. Three subsequently were found not to have atrial septal defects and 2 had congestive cardiac failure associated with atrial septal defects. In these latter 2 patients, Muller's maneuver or elevation of the legs caused a fall in systemic arterial oxygen saturation, enabling the correct diagnosis to be made.

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sion that produces enlargement of the proximal aorta and the aortic ring at the level of the valves. Secondly the aortic valve may have only 2 leaflets instead of 3, and slight enlargement of the aorta may result in insufficiency. Then in the third group there are those instances where disease such as bacterial endocarditis or rheumatic heart disease may cause a loss of valve substance that results in insufficiency. Our experience with aortic insufficiency associated with coarctation of the aorta is limited. We have operated upon 4 such patients. All 4 tolerated the operation well. With a return of the blood pressure to normal, 1 patient lost the signs of insufficiency. Another, although experiencing relief from the preoperative hypertension, continued to have signs of aortic insufficiency and increasing left heart failure, and died almost a year later. The other 2 patients have had a persistence of definite evidence of aortic regurgitation but are definitely improved.

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Dr. Stewart: During the course of the 30 years of this woman’s life, advances in medicine and surgery have come along just in time to help her out of difficulty: antibiotic therapy for subacute bacterial endocarditis and surgery for removal of the coarctation. If she should later need help because of aortic insufficiency or rupture of an aneurysm of the sinus of Valsalva, these conditions too are now within the ever-widening area of cardiovascular lesions, both congenital and acquired, that are amenable to surgery. Close teamwork of the medical and surgical specialties interested in this field has made possible these great steps forward.


The recent Mayo Clinic experience in the management of aortic and iliac arterial occlusive disease is described. In the present series of 99 patients, intermittent claudication was the chief symptom and the status of the leg pulses was the most important physical finding. Preoperative aortography was done routinely in order to define the extent of the occlusions. Technical aspects of resection of the obstructed vessels and homograft reconstruction are outlined. Excellent operative results were obtained in 71 patients (72 per cent) as indicated by complete relief of symptoms and return of leg pulses. Five deaths occurred, all postoperatively. The most important factor in the success of this surgery is insuring that the distal anastomosis is made to a patent artery, if necessary to the superficial femoral.