
Medical Eponyms

By Robert W. Buck, M.D.

Grocco’s Triangle. Professor Pietro Grocco (1857-1916) of Florence first described his triangle at the fourth session of the Twelfth Congress of the Societa Italiana di Medicina Interna in October, 1902. An abstract of his remarks appears under the title “The Paravertebral Triangle on the Side Opposite to Pleurisy with Effusion” (Triangolo Paravertebrale Opposto Nella Pleurite essudativa) in the transactions of the society: Lavori dei Congresso di Medicina Interna 12: 190, 1902 (Rome, 1903).

“Professor Grocco thus designates a new symptom which he has often found in pleurisy with effusion. It consists in a triangular area of relative dulness on the posterior wall of the thorax opposite to the side involved. The internal border of this triangle is represented by the line of the spinous processes, the base by the lower limit of thoracic resonance (which varies somewhat over a space of 3 to 6 cm.), and the external border by a line which extends obliquely upward to the highest point reached by the level of the exudate. Over this area the impairment of sound is more marked toward the median line and toward the base, and the base line itself varies in length and degree of dulness with different positions of the patient as he lies in bed, and with variations in the amount of fluid. The fluoroscope and radiogram confirm the percussion findings. This is illustrated by the accompanying figure, which shows two radiograms, one taken during life, the other from a cadaver in which one pleural cavity was filled with a solution of lead acetate. The test on the cadaver tends to support the idea that the pleural sac, when full of fluid, extends beyond the median line sufficiently and in such a way as to explain the triangle area of dulness above mentioned.”
REGRESSION OF STENOSIS FOLLOWING HEART SURGERY

al norma con le effecto de un complete re-

gression de iste forma secundari de stenosis

infundibular.

Ab le puncto de vista chirurgic, le con-

clusion a derivar ab iste observationes es le

sequeute: Quando le valvula ha essite aperite

complemente, nulle effortio additional a

corriger le stenosis muscular per medios

chirurgic es necessari, excepte in casos in

que il existe un obstruction fixe como per

exemplo un diaphragma o un anulo.

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Hence, since a man may make experiment in many places, it appears that the function of the portal in the veins is the same as that of the Sigmoïdes, or three pointed portals, which are made in the orifice of the aorta or vena arteriosa, to wit that they may be closely shut up, lest they should hinder the blood to return back again.—William Harvey. De Motu Cordis, 1628.
In 1773, John Hunter had his first attack, which was graphically described by his nephew, Everard Home: "While he was walking about the room he cast his eyes on the looking-glass, and observed his countenance to be pale, his lips white, giving the appearance of a dead man. This alarmed him and led him to feel for his pulse, but he found none in either arm; the pain continued, and he found himself at times not breathing. Being afraid of death soon taking place if he did not breathe, he produced the voluntary act of breathing by working his lungs by the power of the will." In 1776 he had a second attack, and when convalescent he visited Bath. Here he was seen by his friend and pupil, Edward Jenner, of Berkeley; and one of the most interesting and sagacious letters of that distinguished man was written to Heberden, giving his diagnosis of John Hunter's case, and suggesting, for the first time, the probable association of disease of the coronary arteries with angina pectoris.—William Osler. *Lectures on Angina Pectoris and Allied States*, 1897.
**ELECTROCARDIOGRAPHIC RECOGNITION OF ATRIAL ENLARGEMENT**

Allargamento dextero-atrial, allargamento sinistro-atrial, e allargamento atrial combinato. Allargamento dextero-atrial es presente quando le proportion del segmentos P a Pr es minus que 1.0. Allargamento sinistro-atrial es presente quando iste proportion es plus que 1,6. Iste constataiones vale sin reguardo al etate del paciente. Le criterios electrocardiographie de allargamento atrial combinato—e le bases theoric de iste observationes—es etiam discutite.

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The excretion of aldosterone and sodium was studied in 30 normal subjects and in 40 patients with various forms of heart failure before, during, and after treatment with digitalis, mercurials, and salt restriction. Healthy people consuming only 60 to 80 mEq. of sodium daily showed increased excretion of aldosterone and decreased excretion of sodium. Nine of 12 untreated patients with severe hydropic heart disease due to combined "left-and right-sided heart failure" excreted moderately increased amounts of aldosterone and reduced amounts of sodium. After cardiac recompensation was re-established sodium and aldosterone excretion was within normal limits. Seven of 8 patients with pulmonary congestion but without systemic symptoms excreted normal amounts of aldosterone, whereas 5 of 7 patients with "right-sided failure" showed moderate to excessive increases in aldosterone excretion. Increased aldosterone activity was also noted in cardiac cirrhosis following abdominal paracentesis and in the first week following myocardial infarctation.

Kurland
BETA-SITOSTEROL AND SAFFLOWER OIL EFFECTS


Five different spectra of proteins were found by paper electrophoresis in the urine of patients with congestive heart failure. All contained albumin, only exceptionally isolated, usually in combination with 1 to 3 globulin fractions, the most common being alpha and beta globulin. Gamma globulins were found in protein-rich urines but also with low protein concentrations following ultrafiltration, suggesting a renal factor contributing to proteinuria in heart failure. The authors believe that the various spectra of globulin fractions may have different prognostic significance.
INTRAMURAL HEMORRHAGE IN CORONARYATHEROSCLEROSIS

Summario in Interlingua

Hemorrhagia intramural est un complicazione commun de atherosclerosis. Illo esseva incontrate in 70 pro cento del masculos e 28 pro cento del femininas de etates de plus que 45 annos sed in nulle patiente de un etate plus juvente. Es discutite le possibilitate que iste hemorrhagia es un factor in le precipitation of acute lesiones occlusive in le arteries coronari.

References

esseva trovate que illo es inter 800 mg e 1,6 g per die in doses dividite. Il pare que le droga merita esser essayate in casos de leve o moderate retention de fluido attribuibile a congestive disfallimento cardiac. Illo es de pauc valor in casos de sever disfallimento cardiac congestive con extreme grados de retention de fluido. In omne casos in que un therapia mercurial es contraindicate, le essayo clinic del droga pare esser justificate.

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In 3 sets of experiments in rabbits, an attempt was made to induce arteriosclerotic changes in pulmonary vessels. It was postulated that repeated emboli caused arteriosclerotic changes, not through organization of emboli, but through repeated arteriospasm and resultant changes in the nutrition of cells in the walls of the vessels because the blood supply was diminished. The experiments were, therefore, designed to induce spasm in the pulmonary vessels. To insure organization, repeated pulmonary air emboli were induced in 1 group of rabbits. Repeated air emboli induced changes compatible with arteriosclerosis in the pulmonary vessels. Arteriospasm was observed in the control animals at the time air emboli were induced. To cause spasm of vessels without emboli, adenosine-triphosphate was injected into another group of rabbits, and although spasm occurred, no arteriosclerotic changes were induced. In a third group of animals, the left pulmonary artery was ligated and emboli were induced in the right lung to see if any hormonal or reflex changes in the left lung resulted, which could cause arteriosclerotic changes. There was no evidence that any arteriosclerotic changes were induced by reflex or hormonal action.


A patient with rheumatic heart disease is reported in whom there was embolization to the systemic arteries and in which the site of origin of the emboli was thought to be the smaller veins of the lungs. Many investigators in reporting the site of origin of systemic emboli in rheumatic heart disease have found a variable number of cases for which no intracardiac source can be demonstrated. The generally held belief, at present, that pulmonary veins are rarely the source of systemic emboli might have to be modified. It is suggested that a more careful dissection of the smaller pulmonary veins in such cases might reveal the source of the emboli.

Bernstein


Five days following an acute myocardial infarction, a 49-year-old man developed signs and symptoms compatible with rupture of the interventricular septum. This complication was confirmed by cardiac catheterization 9 weeks later. Following the perforation of the septum, congestive heart failure appeared and remained a persistent problem, despite a rigid cardiac regimen. Eleven weeks after the perforation, surgical closure of the septal defect was effected through a right ventriculotomy incision and by use of extracorporeal circulation. The defect was approximately 6 cm. in diameter. Repair was accomplished with black silk sutures and polyvinyl sponge. The patient improved remarkably for about 4 weeks following surgery, despite persistence of a soft precordial systolic murmur over the lower sternum. This murmur began to increase in intensity approximately 4 weeks postoperatively. Separation of the sternal wound necessitated a secondary closure. Cardiac failure recurred 6 weeks postoperatively and the patient died a few days later. Autopsy disclosed a healed cardiectomy incision with the polyvinyl sponge still attached in the septal defect but 1 suture had torn out leaving a 0.5 cm. interventricular opening. On the basis of the experience in this patient, the authors speculate that rupture of the interventricular septum as well as other complications of myocardial infarction, such as ventricular rupture with pericardial tamponade, ventricular aneurysm, and ruptured papillary muscle, may prove to be amenable to surgical treatment.

Brothers
ente methodos pro le investigation de iste
mechanismo es relatively crude. Il
remane possibile que le phenomeno in ques-
tion va esser demonstrate per medio de un
systema non ancora discoperite.

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Van Buchem, F. S. P., Nieveen, J., and Van der Slikke, L. B.: The Diagnosis of 
Myxoma Cordis. Diagnosis Established Pre-operatively in Two Cases. Cardiologia 
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The diagnostic features of myxoma of the left atrium are discussed and illustrated by 
the histories of 2 patients recognized during life and confirmed by surgery and autopsy. 
Characteristic findings include a past history of variable signs and symptoms, readily 
influenced by changes in posture and rapid progression of heart failure not responding 
to the usual therapy. Fluoroscopically forceful esophageal pulsations may be observed 
at the level of the left atrium. If the atrial tumor is large enough, cardiac catheteriza-
tion reveals pressure elevation in the right ventricle and in the pulmonary artery. In 
the pulmonary wedge-pressure curve an early positive deflection replaces the normal dip 
during ventricular systole. Finally angiocardiography reveals a filling defect within 
the shadow of the atrium.

Pick
Also, because of the remarkable simplicity of the operation, we have done it in 8 patients. In all the relief of pain was spectacular. The period of observation has been too short for us to make further comment.*

In leaving this aspect of this subject, we really fade out on a feeble chord because we know little about the mechanism that may be back of the relief of pain by interruption of the mammary arteries, if indeed it exists on a permanent basis at all. It could be that there are sympathetic fibers traveling over the mammary arteries that are interrupted, and it might be that it makes a difference whether the veins are interrupted as well. Many surgeons are carrying out this procedure under general anesthesia. We view with some question any operation that is associated with a general anesthetic because these patients are apt to have relief of pain on the nonspecific "common denominator basis" mentioned previously. Our operations have been conducted under local anesthesia. It is a safe, almost office procedure. If you have angina yourself and press firmly on your precordium, you will find that some relief of pain is produced thereby. It is entirely possible that this transverse incision is something like the blocking of reference areas of referred pain. The mechanism is not clear, the facts are not well established, but the present experience is indeed exciting.

Dr. Ellis: We have presented to you in brief form a schema for the long-term management of coronary artery disease. We have had the opinions of several experts as to the current status of certain of the so-called radical methods of therapy. We have not attempted to assess the relative value of one such treatment against another. Most methods must still be considered experimental, and their ultimate value will be established in the course of time by further studies.


In a previous study the authors demonstrated that complete, or almost complete, necrosis of the posterior papillary muscles could be produced in dogs by high ligation of the left circumflex coronary artery and that comparable samples of this region are easily obtainable for both chemical and histopathologic study. Chemical analyses of experimentally produced infarcts showed a 10 per cent loss of potassium in the first 60 to 90 minutes, and a more rapid disappearance during the subsequent 12 hours, when the level had fallen nearly to that contained in extracellular fluid. Histochmical studies using a cobalt nitrite method of precipitation confirmed these results by demonstrating little or no potassium in the fibers at the end of 12 hours. The data suggest that the potassium ion leaves the irreversibly injured fibers at a slow rate during the first 2 hours after injury. Whether this is due to failure of energy-producing mechanisms involved in maintaining the normally high intracellular gradient of potassium or to delayed release of potassium containing proteins is not known.

Maxwell


All of the compounds studied were accumulated in the kidneys. However, there was no obvious relation between site or concentration and diuretic activity. Compounds that were not diuretic were slowly excreted. Certain in vitro inhibitors of sulfhydryl enzymes did not prove to be diuretic. If sulfhydryl inhibition is important in diuresis, compounds that are effective must have different properties from those studied in these experiments. Diuresis probably depends on a fundamental structure; based on the compounds studied it appears that there must be at least a 3 carbon chain included. This chain must have a terminal mercury atom with a hydrophilic group at least carbon atoms distant.

OPPENHEIMER