ACKNOWLEDGMENT
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SUMMARIO IN INTERLINGUA
Studios hemodynamic eseva correlationate con le curso clinic de pericarditis constrictive in un serie de 6 patientes. In 2, le reversibilitate del phenomenos congestive es explicate per le resorption del fluido in un rigide spatio pericardial. Le 4 altere patientes monstrava per contrasto le curso progressive de classic constrictive pericarditis chronic.
Le discreptantia inter symptomas e nivello del pressiones intracardiacae es discutite.

REFERENCES

Cheyne-Stokes Respiration. A form of respiratory distress, peculiar to this affection, consisting of a period of apparently perfect apnoea, succeeded by feeble and short inspirations, which gradually increase in strength and depth until the respiratory act is carried to the highest pitch of which it seems capable, when the respirations, pursuing a descending scale, regularly diminish until the commencement of another apnoeal period. During the height of the paroxysm the vesicular murmur becomes intensely puerile.—William Stokes. The Diseases of the Heart and the Aorta. Dublin. 1854.
Tracings taken on December 11 and 17 showed progression of the degree of T-wave inversion. One taken on December 21 (fig. 3) showed maximum T-wave inversion in leads II, III, aVr, and V<sub>1</sub>; the QRS complexes remained normal.

He was discharged improved, and at present is healthy. His tracing has returned to normal and he has had no recurrence of symptoms.

**RESULTS**

The data are presented in table 1. Thirty-one patients showed changes in the precordial leads; 14 showed changes in leads II, III, and aV<sub>1</sub>. The single atypical case to die was an elderly, obese, diabetic woman (case 19) who clinically would not be called atypical or mild. The single complication in an atypical case was a bout of transient atrial fibrillation.

Seven patients showed significant ST-segment elevation. Only 4 of the atypical cases showed a delay in the development of electrocardiographic abnormalities; 1 of these did not develop changes until 2 weeks after the episode of pain and muscle damage; of the others, 2 developed changes in 5 days and 1 in 1 week.

The results are summarized in table 2.

Of the 43 patients who survived the initial attack, follow-up data were obtained in 33 and these are summarized in table 3. The number of patients is too small to permit conclusions but the data suggest that the long-term prognosis may be more favorable than that following typical infarction.

Table 4 compares the incidence of atypical infarcts in this study with those from previous studies.

**SUMMARY**

The small, atypical myocardial infarct is a clinical entity, and the electrocardiogram can be of great help in making this diagnosis. The immediate prognosis in this type of case is excellent.

**SUMMARIO IN INTERLINGUA**

Le micro, atypic infarce myocardial es un entitate clinic. Le electrocardiogramma pote esser de grande adjuta in establir le diagnose. Le prognose immediate es excellente.

**REFERENCES**


It is greatly to be doubted, that angina pectoris has ever occurred in a patient perfectly free from organic disease of the heart or aorta; and it is more probable that, in the cases so described, the disease was overlooked, than that the heart was perfectly sound.—William Stokes. The Diseases of the Heart and the Aorta. Dublin. Hodges and Smith, 1854, p. 482.
COMPLICATIONS OF ANASTOMOTIC SURGERY

aneurysmal del artery pulmonar, decrescen-
tia, del derivation retorno de cyanose, disfalli-
mento cardiac, e morte.

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M. J. 1: 1375 (June 15), 1957.

The physical signs, radiologic findings, electrocardiographic changes and differential
diagnosis of atrial septal defects are discussed and various clinical and catheterization
data are presented for 100 patients studied by the authors. Of this group the diagnosis
was proved by catheterization or necropsy in 66 patients, including 7 with anomalous
pulmonary venous drainage and 8 others with pulmonary valvular stenosis in addition.
In the other 34 patients the diagnosis seemed certain on clinical grounds. Observation
of the course of these patients indicates that after infancy is passed the first 2 decades are
relatively normal periods, but the prognosis in the fourth and fifth decades is much less
good and only one half of these seen at the hospital are still well at 40 and less than a
quarter at 50. Usually the heart is large, often of such size as would generally indicate
a poor prognosis, but nearly all patients who survive the first year or so do well without
the heart becoming any larger until 25 and more often 35 years of age. Then, in an
increasing number, but not in all, the strain of the large right ventricular output produces
increasing dyspnea and ultimately right-sided heart failure. In some patients pulmonary
arterial pressure rises, reversing the shunt and producing central cyanosis and pulmonary
artery thrombosis.

SAGALL
phoresis sur papier, Presse méd. 65: 909, 1957.


Medical Eponyms

By Robert W. Buck, M.D.

Hanot’s Cirrhosis. Victor Charles Hanot (1844-1896) presented “A Study of a Type of Hypertrophic Cirrhosis of the Liver (Hypertrophic Cirrhosis with Chronic Jaundice)” (Étude sur une forme de Cirrhose hypertrophique du foie (Cirrhose hypertrophique avec icterus chronique)) to the Paris Faculty of Medicine as his thesis for the doctorate. This is Thesis No. 465 of the Faculty of Medicine of Paris, and was published in 1875. The following quotation is taken from page 89.

“Among the various lesions of the liver which have been included under the name of hypertrophic cirrhosis, there is one which is distinguished by the following features: intralobal sclerosis, abnormal development and chronic catarrh of the smaller bile ducts.

“The clinical form is no less characteristic: It is an affection which first shows itself by chronic jaundice, due to obliteration of the smaller bile ducts, and by a considerable hypertrophy of the liver without ascites or abnormal enlargement of the subcutaneous abdominal veins such as is seen in classic cirrhosis.

“Usually this disease follows a prolonged course, and may continue for several years without any marked alteration in the state of nutrition. It also usually terminates in the syndrome known as icterus gravis.

“By reason of all these peculiarities, it would seem to deserve a separate place in the nosological category. One might term it hypertrophic sclerosis of the liver with chronic jaundice.”
SPLANCHNIC BLOOD VOLUME IN CONGESTIVE HEART FAILURE


A physician may possess the science of Harvey and the art of Sydenham, and yet there may be lacking in him those finer qualities of heart and head which count for so much in life.—British Medicine in Greater Britain. Montreal Med. Journal, 1897.


This report summarizes the operative experience since 1945 of 36 prominent cardiovascular surgeons from several continents. Without surgical treatment, individuals with coarctation of the aorta have an average life expectancy of 32 years or less, and only 1 in 10 lives past the age of 50. Operation consists of resection of the coarcted segment; and the aortic defect may be bridged either with a homograft or with a woven plastic tube. Operative mortality rates in 1,601 patients averaged 8.6 per cent; and these deaths were attributed mainly to circulatory failure (33 patients) disruption of the anastomosis (28), ventricular arrest or fibrillation (18) or hemorrhage usually from dilated intercostal arteries (16). The postoperative results were satisfactory in 96 per cent of the 1,405 or more patients surviving operation by 3 months or longer. The blood pressure had returned to normal in 72 per cent and had been substantially reduced in an additional 23 per cent. Better results in the treatment of this relatively uncommon disorder are anticipated in the future from improvements in surgical technique and from the operations being done during childhood when operative mortality rates are lowest.

Rogers


The anastomoses between coronary arteries present in the normal heart provide a basic collateral circulation, which while not sufficient to maintain myocardial contractions following acute interruption of the normal arterial supply, generally enable the survival of variable amounts of myocardium providing death does not follow the occlusion. In the survivors there is a gradual enlargement of collateral circulation quite variable in amount but sufficient to enable the ischemic myocardium to regain its contractile ability. The collateral blood comes exclusively from other arteries. The nearest artery or the anatomically shortest path of least resistance appears to be the commonest source and route.

Collateral coronary circulation was discussed from the standpoints of a historical review, physiologic studies of collateral coronary circulation, surgical approach to augmenting collateral coronary circulation, including abrasion of heart and pericardium, coronary sinus ligation, acute arterial retroperfusion of the coronary sinus, chronic arterilization of the coronary sinus, the mechanism of protection of arterial retroperfusion of the coronary sinus, implantation of internal mammary artery into myocardium, and metabolic factors operative in the augmentation of collateral coronary circulation. If and when it is possible to reduplicate the experiments of nature and completely interrupt all the normal inflow to the myocardium with survival, it should be possible to trace and measure the blood flow from the extracardiac arterial sources. Careful studies of treated and untreated groups with long-term follow-up are needed before precise answers can be reached. Much is yet to be learned, but the evidence at hand indicates that a firm foundation has been established for improving collateral circulation to the myocardium by surgical means.

Maxwell
years' duration. Seventeen (41 per cent) had abnormal patterns, 2 of whom also had abnormal electrocardiographic patterns. It is suggested that the abnormalities were related to the early development of coronary sclerosis.

**Summario in Interlingua**

Ballistocardiogrammas esseva obtenite ab 41 juveniles con diabete de plus que 10 annos de duration. In 17 (41 pro cento) le configurationes ballistocardiographic esseva anormal. In 2 del 17, etiam le configurationes electrocardiographic esseva anormal. Es opinate que le anormalitates esseva le efecto de un disveloppamento precoce de sclerosi coronari.

**References**


Elevation of serum oxalacetic transaminase is not specific for any particular disease but depends upon a number of factors contributing to serum transaminase levels. On the other hand, glutamic-pyruvic transaminase is said to be more specific for detection of hepatocellular damage and less sensitive as an indicator of myocardial necrosis. The serum concentrations have been correlated with the enzyme concentrations in the respective tissues involved. In this report, the sera of 150 patients were compared with respect to oxalacetic and pyruvic transaminase activities to determine the value of the latter in a variety of disease states. In 24 patients with myocardial infarction the serum oxalacetic transaminase was elevated; pyruvic transaminase was elevated in some and normal in others. In patients with hepatic disease including hepatitis, cirrhosis, cancer, and hepatic necrosis and in acute pancreatic necrosis, both transaminases were elevated. Four of 5 patients with viral hepatitis had higher serum pyruvic transaminase than oxalacetic transaminase levels. The highest levels of activity were noted during the initial phase of viral hepatitis. In extrahepatic obstructive jaundice, both transaminases were elevated; slight elevations occurred in both serum enzyme levels in infrahepatic obstructive jaundice. These findings indicate that serum pyruvic transaminase is not more sensitive as an indicator of hepatocellular damage nor is it specific for this condition. The pyruvic transaminase assay should find its greatest use as an adjunct in the interpretation of an elevated oxalacetic transaminase level.

Shuman