


We celebrate the memory of great men in the certain hope that in their children they will be born again.—Thomas Clifford Allbutt, M.A., M.D. Science and Medieval Thought. London, C. J. Clay & Sons, 1901, p. 112.
anomalous muscle were confused surgically with the ventricular septal defect.

In the remaining six cases, the anomalous muscle bundle caused obstruction within the right ventricular cavity. Five of these patients had associated ventricular septal defect, with a clinical picture resembling that of the cyanotic or acyanotic tetralogy of Fallot. The cases served to demonstrate that the surgeon who exposes the right ventricle to relieve an obstructive lesion in the right ventricular infundibulum or in the pulmonary valve, may find no such lesions in these locations but instead may be dealing with an obstruction more proximal than these areas. Relief of the obstruction within the right ventricle may be attained by resecting the anomalous muscle mass.

In one patient having intact ventricular septum and pulmonary valvular stenosis, an anomalous muscle bundle within the right ventricle which lay proximal to the infundibulum was responsible for persistent right ventricular obstruction after pulmonary valvotomy.

Anomalous muscle bundles in the right ventricle may be suspected when, in the angiocardiogram, they cause filling defects within the right ventricle.

References

The Early History of Instrumental Precision in Medicine

From the days of Elizabeth every man of fashion, and especially the English, traveled in Italy. Here, too, wandered all who studied, or were fond of science, and it was to Padua—which Sanctorius called the Garden of Science—that Bacon came, and Drebble, and Fludd, and the greater Harvey. The towns of Italy were exchanges of Europe both for commerce and for science. From them men took home what facts they saw or heard, and merely describing them (as did Bacon the air thermometer), left the future critic to settle the question of originality. The temper of the time was not that of our day. Men worked along patiently. There were no journals; the letter or the lecture were the only means of early publication. The genius who today invents a new forceps...yearns for instant type, and defends his offspring with virulence. Harvey knew of his great discovery in 1616, and it got into print in 1628. His lecture notes show that long before this date he was certain of the matter and clearly knew what he had done.—S. Weir Mitchell, M.D., Transactions of the Congress of American Physicians and Surgeons, Second Triennial Session held at Washington, D.C., 1891. New Haven, The Congress, 1892, p. 168.

On Permanent Patency of the Mouth of the Aorta, or Inadequacy of the Aortic Valves

By DOMINIC JOHN CORRIGAN, M.D.

One of the Physicians to the Charitable Infirmary, Jervis Street, Dublin; Lecturer on the Theory and Practice of Medicine; Consulting Physician to St. Patrick's College, Maynooth

The disease to which the above name is given has not, so far as I am aware, been described in any of the works on diseases of the heart. The object of the present paper is to supply that deficiency. The disease is not uncommon. It forms a considerable proportion of cases of deranged action of the heart, and it deserves attention from its peculiar signs, its progress, and its treatment. The pathological essence of the disease consists in inefficiency of the valvular apparatus at the mouth of the aorta, in consequence of which the blood sent into the aorta regurgitates into the ventricle. This regurgitation, and the signs by which it is denoted, are not necessarily connected with one particular change of structure in the valvular apparatus, and hence the name Permanent Patency of the Mouth of the Aorta, or Inadequacy of the Aortic Valves, has been chosen as simply expressing such a state of the parts as permits the regurgitation to occur.
CHRONIC CONSTRUCTIVE PERICARDITIS

carditis; report of a case which progressed to constrictive pericarditis, requiring relief by pericardiectomy. New Zealand M. J. 56: 124, 1957.


It is common error to think that the more a doctor sees the greater his experience and the more he knows.—Sir William Osler. Aphorisms From His Bedside Teachings and Writings. Edited by William Bennett Bean, M.D. New York, Henry Schuman, Inc., 1950, p. 48.


The Early History of Instrumental Precision in Medicine

Thinking over the number of instruments of precision, a single case may require, it is clearly to be seen that no matter how expert we may be, the diagnostic study of an obscure case must today exact an amount of time far beyond that which Sydenham may have found need to employ. A postmortem section used to take us an hour or two, and now, alas! it goes on for weeks in some shape until the last staining is complete, the last section studied, the last analysis made.

These increasing demands upon us are due to the use of instruments of precision, or to accurately precise methods. As in factories more and more exact machines have trained to like exactness a generation of workmen, so with us, the use of instruments of precision, rendering the comparison of individual labor possible, has tended to lift the general level of acuteness of observation. The instrument trains the man; it exacts accuracy and teaches care; it creates a wholesome appetite for precision which, at last, becomes habitual. The microscope, the balance, the thermometer, the chronograph have given birth to new standards in observation, by which we live, scarce conscious of the change a generation has brought about. Certain interesting intellectual results have everywhere followed the generalisation of precision by the use of instruments, like the world-wide lesson in punctuality taught by the railway and made possible by the watch. . . . For unless men keep ahead of their instrumental aids, these, to coin a word, will merely dementalize them, but measurably lift the mass without in proportion advantaging the masters of our art, who were so easily masters in days when the erudite touch was more uniquely advantageous than it is today.—S. WEIR MITCHELL, M.D., Transactions of the Congress of American Physicians and Surgeons, Second Triennial Session held at Washington, D.C., 1891. New Haven, The Congress, 1892, p. 164.
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In the perfect state of the mechanism at the mouth of the aorta, the semilunar valves, immediately after each contraction of the ventricle, are thrown back across the mouth of the aorta by the pressure of the blood beyond them, and when adequate to their function of closing the mouth of this vessel, they retain in the aorta the blood sent in from the ventricle, thus keeping the aorta and larger vessels distended. These vessels consequently preserve nearly the same bulk during their systole and diastole. But when the semilunar valves, from any of the causes enumerated, become incapable of closing the mouth of the aorta, then after each contraction of the ventricle, a portion of the blood just sent into the aorta, greater or less, according to the degree of the inadequacy of the valves, returns back into the ventricle. Hence the ascending aorta and arteries arising from it, pouring back a portion of their contained blood, become, after each contraction of the ventricle, flaccid or lessened in their diameter. While they are in this state, the ventricle again contracts and impels quickly into these vessels a quantity of blood, which suddenly and greatly dilates them.

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I have three personal ideals. One, to do the day’s work well and not to bother about tomorrow . . . The second ideal has been to act the Golden Rule, as far as in me lay, toward my professional brethren and toward the patients committed to my care. And the third has been to cultivate such a measure of equanimity as would enable me to bear success with humility, the affection of my friends without pride, and to be ready when the day of sorrow and grief came to meet it with the courage befitting a man.—Sir William Osler. Apohisms From His Bedside Teachings and Writings. Edited by William Bennett Bean, M.D. New York, Henry Schuman, Inc., 1950, p. 84.
diography. The most prominent conditions to be considered in a differential diagnosis would be rupture of an aortic valve cusp, ventricular septal defect with deformity of the aortic valve and aortic insufficiency, bronchial arteriovenous fistula, and coronary arteriovenous fistula. A patent ductus arteriosus and a venous hum should readily be distinguished by their location.

The prognosis after rupture has been mentioned. The general impression one gains from a review of the literature is that, in most instances, rupture foretells a rapidly fatal outcome. In the individual case, prognostication will be aided by determining shunt volume and the physiologic effect the abnormal flow has on the cardiovascular system, as determined by symptoms, x-ray and electrocardiographic findings, and pressure measurements.

Treatment of the defect is obviously surgical with the best method of closure to be determined with the wisdom more case experience will afford. Four different methods of repair have been reviewed in this report. Edwards stresses the point that proper repair requires that the aortic wall be reunited, either directly or indirectly by prosthesis, with the heart. Mere closure without reuniting the aortic media with the heart fails to overcome the basic lesion.

Summary

Two cases operated upon for ruptured sinus of Valsalva aneurysm are presented and discussed. Operations done previously for this condition are noted. Aspects of the deformity that are pertinent to its recognition and treatment are briefly reviewed.

References


Medicine is a science of uncertainty and an art of probability.—Sir William Osler.