A colored man, aged 47, who had gonorrhea 23 years ago, but lues was denied.

One year ago, had what he described as pleurisy on the left side. Present pain is similar to that of one year ago. No other diseases or injuries.

Present complaint is pain on right side of chest and lower dorsal spine for the past four to six weeks. Pain has been constant for the past four weeks; worse on inspiration. Slight cough, no expectoration and no hemoptysis. No acute infection.

Physical examination revealed a well developed, well nourished colored man, who is making an effort to splint his right side. His blood pressure was 130/85. Pupils react to light and accommodation. Heart sounds normal. Lungs normal. Palpation of dorsal spine reveals a localized area of tenderness over D 10. Wassermann one year was negative.

X-ray examination reveals a large circular mass in the posterior mediastinum, encroaching upon the left pulmonic field. The trachea is displaced anteriorly, and the left main bronchus is compressed and elevated. The left pulmonary artery is elevated and surrounds the mass.

**Answer: Segmental Dilatation of Aorta.**

Angiocardiographic examination reveals a huge segmental dilatation in the descending aorta, with no evidences of coarctation.

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**CLINICAL APPLICATION OF CORONARY ANGIOGRAPHY**

Coronary angiography has been used as a routine investigation to obtain additional information regarding the blood supply to the myocardium. It was possible to make a partial check of the angiographic findings at operation. No important discrepancy was detected. It is therefore considered that this is a reliable and safe procedure that should be carried out when additional information is required concerning the coronary circulation. In patients with aortic valve disease, it may be important to know the state of the coronary circulation before deciding on the advisability or type of operation to be performed.

Visualization of the coronary circulation might assist in the diagnosis of chest pain when the electrocardiogram is found to be normal. The demonstration of completely normal major coronary vessels would greatly assist the physician in his management.


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**ACQUIRED VALVULAR LESIONS**

The monopoly previously enjoyed by congenital defects for the facilities of open-heart surgery is being rapidly challenged by an increasing number of acquired lesions that are now amenable to successful repair. These are primarily acquired valvular deformities resulting from rheumatic fever. Even with the measures of prophylaxis against rheumatic fever that now are being implemented, significant reduction in the number of patients with rheumatic valvular disease cannot be expected for another 20 to 25 years, so that this area of responsibility for the cardiac surgeon remains vast.