ROENTGENOGRAM OF THE MONTH

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CLINICAL INFORMATION

This 39-year-old woman was admitted to Emory University Hospital on October 19, 1959 for a severe upper respiratory infection. The admission film revealed a superior mediastinal mass. Her only other hospitalization was in 1954 following a severe automobile accident which resulted in pneumothorax and probable intra-abdominal contusions. Since that time she complained of frequent colds and chronic cough productive of moderate amounts of yellow sputum. Physical examination was unremarkable. The blood count, urinalysis, fasting blood sugar, and electrocardiogram were within normal limits.

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Diagnosis: Traumatic Aneurysm of the Aorta

The posteroanterior film of the chest (Fig. 1) reveals a rounded well-circumscribed mass just above the left hilum. The mass appears continuous with the lower portion of the aortic knob obliterating its lateral margin. No calcium can be identified within the knob or the mass. The left first, second, and third ribs are deformed as a result of previous fracture. An aortogram the following day confirmed the presence of an aneurysm. Aneurysmorrhaphy was performed, and she had an uneventful recovery.

Aortic aneurysms may be syphilitic, arteriosclerotic, mycotic, congenital or traumatic in origin. Traumatic etiology is suggested by the presence of old fractures and a past history of severe chest injury, especially from automobile accidents. The sudden deceleration probably plays an important role in the development of these false aneurysms. The most frequent site of traumatic aneurysm is the junction of the aortic arch with the descending aorta, just distal to the origin of the left subclavian artery. It is presumed that the aorta is not so tightly supported at this point. The aneurysm generally does not appear until several weeks after the injury. The tear in the aortic wall results in a walled-off hematoma which later forms the wall of the false aneurysm. A long-standing traumatic aneurysm may contain calcium in its wall. Rupture may occur soon after the injury, but perforation is infrequent in chronic aneurysm.

References

MEDIASTINAL TUBERCULOSIS

Uncommon course and complications of tuberculosis of the mediastinal lymph nodes are presented. This form of tuberculosis may result in diffuse inflammatory lesions of the mediastinal region, leading to chronic processes with fibrous proliferation, "mediastinitis chronica fibrosa." The disease may be dominated by the disturbances in venous circulation in the form of superior vena caval syndrome. Three cases of this type are presented in which the tuberculous background was confirmed on two occasions by post-mortem examinations. In the third case, the same etiology was assumed by the exclusion of other conditions.

Esophageal lesions are another complication due to tuberculosis of the mediastinal lymph nodes, including inflammatory tract diverticula as a mild form of pathology. A more severe complication occurs in the presence of esophago-tracheobronchial or pulmonary fistula. Two cases of esophageal fistula and one case of multiple esophageal diverticula are described.


CLINICAL PICTURE AND TREATMENT OF ACUTE PNEUMONIA

Subject to analysis were the clinical signs and results of 219 patients with acute pneumonia, including 71 patients with croupous and 148 with focal pneumonia. In a considerable number of patients with croupous pneumonia, a number of typical signs of the disease is frequently absent; in 50 per cent of cases, there was no lobar, but segmental affection. Combined treatment with antibiotics (penicillin) and sulfanilamides results in abatement of acute manifestations of the disease and intoxication within the first three to five days. However, resolution of the infiltrate occurred at a considerably slower rate—sometimes until the 30-35th day of the disease, this being conducive to the development of pneumosclerosis.