A 54-year-old white man was admitted to the hospital because of Morgagni-Adams-Stokes attacks of ten months duration. As a child, the patient had frequent episodes of epistaxis and pharyngitis. At age 34, he was rejected for military service because of a "heart murmur." The Morgagni-Adams-Stokes episodes increased in frequency and severity, and one week prior to admission, several episodes of syncope with convulsions occurred upon attempting to stand in the upright position. On examination, the patient was pale and apprehensive. His temperature was 99°F., blood pressure was 160/70 mm. Hg, and the apical pulse, 31 beats per minute. There was moderate distention of cervical veins with large atrial waves occasionally noted. The left ventricular impulse was palpated at the anterior axillary line between the sixth and seventh ribs, and the first apical sound varied in intensity. A grade II holosystolic murmur and an intermittent third sound were heard at the apex and along the left sternal border. The electrocardiogram...
demonstrated complete heart block with a ventricular rate of 31 per minute, and an atrial rate of 75 per minute.

After admission to the hospital, five episodes of cardiac asystole occurred which required external cardiac massage and utilization of the external pacemaker to maintain an effective circulation. Intravenous isoproterenol hydrochloride, atropine sulphate, and epinephrine were administered without improvement in rate or rhythm. An internal pacemaker was implanted with the ventricular rate preset at 62 per minute.

Microscopic sections of the pericardium, myocardium, and endocardium demonstrated non-specific inflammatory changes suggestive of rheumatic carditis.

The postoperative period has been most satisfactory, and during the past seven months there have been no cardiovascular symptoms. The continuous electrocardiographic recording illustrated in Fig. 1 demonstrates periods of retrograde atrial conduction alternating with supraventricular conduction. Ventricular conduction follows the electrical stimulus (S) at a rate of 62 per minute. Supraventricular atrial conduction (x) at a rate of 73 per minute is independent of ventricular conduction due to the complete heart block. As the atrial refractory period terminates, following the normal period of conduction (y), the atria appear to accept the ventricular stimulus from below the A-V node, and depolarize in a retrograde fashion (RC) most likely through an aberrant pathway at a rate (z) slightly greater than the ventricular rate. Whenever the refractory period terminates, and there is no stimulus from below to activate the atria, then the sino-atrial node again initiates atrial depolarization.

CHRONIC PNEUMONIAS AND CANCER OF THE BRONCHUS

Two hundred fifty patients with bronchial cancer proved histologically and 120 patients discharged from the hospital with the diagnosis of chronic pneumonia were subjected to the detailed clinicostatistical analysis and kept under the dispensary control. The terms of the dispensary control in the last group of patients were two to seven years. The analysis of data obtained permits the authors to state that the incidence of bronchial cancer is higher on the background of continuous inflammatory processes than in the absence of the latter. The significance of pneumonia as an associated process in cancer of the bronchus complicating the principal lesion and hampering the establishment of its diagnosis deserves emphasis.


POSTOPERATIVE RUPTURE OF ESOPHAGUS

Two patients with postanesthetic rupture of the esophagus are described. In one instance, antemortem diagnosis was made; in the second, the cause of death was established post mortem.

Although rupture of the esophagus has been known to occur spontaneously, in most instances there is weakening of the esophageal wall, esophagomalacia, due to chronic disease, protein deficiency, or stress conditions, coupled with a precipitating factor, that is, an increase in intraluminal pressure due to distension, vomiting, or retching. Onset of vomiting 12 to 24 hours postoperatively associated with hematemesis and followed by extreme restlessness, sweating, hypotension, tachycardia, chest pain and pulmonary and circulatory collapse should be considered as possible signs of a rupture of the esophagus. Early diagnosis and prompt therapy is of paramount importance since the prognosis, in general, is poor.