superannuation. These people are just as integral a part of the service as any radiographer (soon to be married), hospital secretary, or any other normally superannuated medical ancillary, and it is a belated justice that must be done. None of our staff had any qualification for ancillary medical service in the way of formal training when they came to us. They each had intelligence, loyalty, willingness to work, and a sense of team work. None of these qualities can be taught, but if any training scheme is to avoid producing people all content to occupy their own clearly defined niche and be therefore useless in general practice, these qualities must be demonstrated in action.

CLINICAL NOTE

AN INTERESTING CASE OF CARDIOVASCULAR COLLAPSE

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A CASE IS DESCRIBED OF sudden collapse in a man of early middle age. On 6 December 1963 at about 2 p.m. Mr XY was seen as the result of an emergency call. He had been found collapsed on the kitchen floor by his wife and although conscious he was confused and unable to give any history.

Personal history. Mr XY was aged 46 and the owner of a village general stores. In addition he carried on his trade as a painter and decorator. He had led an active life but had been moderately overweight in recent years. Patient took an occasional pint of beer and smoked 20–30 cigarettes daily.

Family history. Father died at 70 after repeated attacks of coronary thrombosis and a history of angina for several years. Mother died at 42 of tuberculous meningitis. Brother, alive and well aged 50. Sisters, two alive and well, aged 49 and 44.

Previous history. Mr XY suffered malaria during the 1939–45 war. He had synovitis of the right knee in July 1948, and there was a further attack in 1960 and consultant's opinion was that there might be damage to the meniscus. In December 1960 the patient had an attack of upper retrosternal pain lasting for 30 hours, aggravated by deep breathing, but unaffected by exertion. Subsequently he complained of some vertigo, and a slight pain in the left breast. Examination showed a mild hypertension 170/95 and (?) faint apical and aortic systolic murmurs. At this

time he was extremely anxious in view of his father's fatal illness. In March 1960 his electrocardiograph and chest x-ray were within normal limits. There was no history of rheumatic disease.

Present illness. Mr XY's wife had been confined to bed for a few days, and in addition to his work he had walked up and down stairs more than usual.

On 6 December 1963 he was found in a collapsed state on the kitchen floor. On examination he was conscious but confused. He was sweating profusely, very pale and with some cyanosis of his lips. His pupils were equal and reacted to light, and there were no abnormal neurological signs. His pulse was of poor volume, rate 92 and regular, his blood pressure 45/20. He was not dyspnoeic and there were no abnormal signs in the chest. His heart sounds were distant and no murmurs were heard. He was given morphine and mephine intramuscularly. He complained of nausea constantly and after about 15 minutes he vomited copiously. There was no chest pain at this stage. After three hours he was still vomiting and was now rational, he complained of faint pain in the left breast. His blood pressure remained at 45/20 and no new physical signs were noted. After eight hours the vomiting ceased and the patient recalled that immediately prior to the incident he had felt sick, and was trying to walk across to the kitchen sink. He was comfortable lying flat with the foot of the bed raised, his blood pressure 50/20.

On 7 December 1963 patient felt better, the vomiting had ceased, he was still very pale, blood pressure 70/25, and pulse unchanged and still regular. Auscultation did not reveal anything new. Mr XY now complained of weakness of the left arm and a short spell of diplopia, there was also some tingling of the tongue. Examination showed that he had a paresis of the left forearm and hand. Throughout his illness the pupils were normal and there was no complaint of headache. On 8, 9 and 10 December 1963 patient improved slowly but was still hypotensive. On 11 December 1963 the blood pressure was 75/25 and the patient had developed loud systolic and diastolic murmurs in the aortic area. The left arm paresis had improved leaving only slight weakness. There was one further episode of diplopia when the patient attempted to sit up without permission. On 12 December 1963 Mr XY developed acute dyspnoea during the morning, this lasted for two hours and was accompanied by a few moist sounds at both bases. He was treated with aminophylline and given a prophylactic course of oxytetracycline. He was apyrexial throughout.

Apart from a short further bout of dyspnoea on 15 December, no further symptoms occurred. During the early days he was given largactil and nepenthe, and continued well on aminophylline. Gradually his systolic blood pressure climbed to 110 but the diastolic remained at 25–30. He progressed slowly and by mid-January he was considered fit to attend hospital for investigation. On admission Mr XY was found to have aortic systolic and diastolic murmurs with no thrills. He had triple rhythm and slight weakness of the left hand. Chest x-ray on 9 January 1964 showed an increase in the transverse diameter of the heart, and there was a little unfolding of the aorta. Screening confirmed enlargement of the left

ventricle, and some unfolding of the ascending thoracic aorta. There was no intracardiac calcification.

Electrocardiography showed abnormalities in the chest leads. Lead V6 showed tall R waves, depression of the ST segment, flattening of the T wave and slight prolongation of the QRS complex. Lead V4 showed tall R waves. Lead V2 showed deep S waves and elevation of the ST segment. Taken together these indicate a moderate degree of left ventricular hypertrophy. Blood Wasserman was repeatedly positive. There was a weak positive Meinicke test. Treponemal immobilization test was also positive. Investigation of the cerebrospinal fluid revealed no specific involvement.

Mr XY was treated by a 30-day course of intramuscular penicillin and given potassium iodide. The latter was discontinued as the patient developed signs of iodism.

Now, in December 1964, he is symptom free and able to manage light work. He has aortic murmurs in both phases, a water hammer pulse and blood pressure 150/50/25.

Discussion

A case of sudden collapse associated with extreme shock is described, the outstanding symptom being vomiting. Cerebrovascular accident in the absence of any neurological signs, and in the presence of severe hypotension and shock with the patient still retaining consciousness, seemed unlikely. Observation for a short period excluded an acute abdominal catastrophe. At the time a diagnosis of atypical cardiac infarction was made. The subsequent development of diplopia and left arm paresis was due to hypoxia due to the prolonged hypotension. Two attacks of acute dyspnoea showed some degree of left ventricular failure. The appearance of the loud aortic murmurs on the fifth day altered the diagnosis, and it seemed obvious that some acute embarrassment of the aortic valve had occurred. A tentative diagnosis of a rupture of an aortic cusp or a dissecting aneurysm was made.

Hospital admission proved that the patient was suffering from syphilitic aortitis. It was evident that the heart had accommodated itself to the new conditions—by the absence of symptoms and the demonstration of left ventricular hypertrophy. It seems therefore that the final diagnosis rests between a small dissecting aneurysm or acute dilatation of the aorta, the latter being the most likely.

Apart from the one attack of pain in 1960 and mild left breast pain for a few weeks the patient had been symptom free. At no time prior to his present illness had he complained of nocturnal or indeed any dyspnoea. He was examined for life assurance in September 1962 and there were no abnormal signs in the heart, the blood pressure being 140/80. The significance of this earlier pain is difficult to assess, it was thought to be chiefly functional, the father having recently succumbed with angina. In retrospect it could have been due to spirochaetal invasion of the aorta. It certainly could not be due to involvement of the coronary arteries as the infection attacks the orifices of the latter causing stenosis, and pain of progressive severity.

In general, the diagnosis of syphilitic cardiovascular disease derives

from four situations, (*a*) the accidental discovery of aortic diastolic murmurs, (*b*) the presence of angina, (*c*) the signs of cardiac failure and (*d*) the signs of an aneurysm of the thoracic aorta—these being pain, occasionally the presence of a pulsating tumour and the pressure effects on the surrounding structures.

Sudden death is well known in this condition, and it appears that this patient was able to cheat death by a remarkable adaptation to adversity.

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OVERSEAS NEWS

RECENT DEVELOPMENTS IN GERMANY AND AUSTRIA

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THE PROBLEMS OF ARRANGING training facilities for general practice in Germany and Austria are very much on the agenda of conferences, congresses and less formal meetings between leading practitioners, chiefs of policlinics and university departments of medicine.

Dr Engelmeier, secretary of the International College of Medical Practice, reports the result of his visit to a policlinic in a small German university town. These clinics, where representatives of the specialities are found with the facilities corresponding to those found in a British outpatient clinic, had been put forward as suitable training centres for the future general practitioner. In spite of the open access of the general population to these clinics Engelmeier found, and in this he was confirmed by replies to a questionnaire received from 50 general practitioners, that the majority of cases seen at a policlinic had already been sieved off from the mass of unselected material seen in general practice. The patient with the ill-defined symptoms which sometimes herald serious illness (Braun's potentially dangerous conditions), but more usually run their short course without a diagnosis having been established, does not present himself at the policlinic.

In addition there is a fundamental difference in the approach to the patient. Lack of time prevents the general practitioner from carrying out the exhaustive diagnostic routine of the clinic doctor, but he has, on the other hand, the advantage of usually knowing the personal background of his patients. In spite of these differences a number of policlinics in western Germany, in particular in Hanover and Giessen, are starting departments of general practice.

Another discussion between heads of clinics and members of the