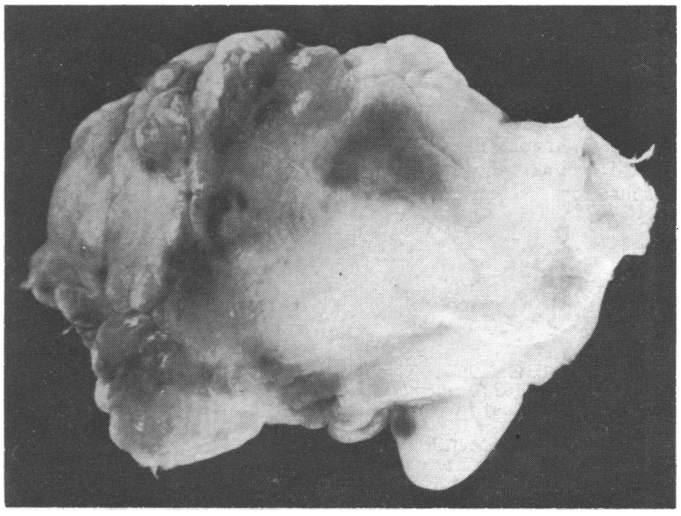

Lobulated calcified myxoma (4 x 5 cm) removed from left atrium.

The myxoma was excised and the mitral valve replaced with a No. 3 Starr-Edwards prosthesis (6120). Convalescence was uneventful and subsequent cardioversion restored sinus rhythm.

Comment

Harvey (1968) used the term "wrecking ball" to describe the movements of a calcified pedunculated right atrial myxoma, likening it to the swinging iron ball suspended from a crane used for demolishing buildings. In the patient he described the tricuspid valve had been almost completely destroyed by the movements of the tumour. Similar patients with incompetent tricuspid valves damaged by calcified right atrial myxoma have been reported by Oliver and Missen (1966) and Fluck and Lopez-Bescos (1968). Predominant mitral regurgitation, though unusual, has been described in a few patients with myxoma of the left atrium (Cohen *et al.*, 1963; Penny *et al.*, 1967; Wittenstein *et al.*, 1959). It was attributed to partial herniation of the tumour through the mitral valve interfering with valve closure. Ruptured chordae tendineae were not seen. The present patient, unlike most others with left atrial myxoma, presented with a sudden onset of severe mitral regurgitation and pulmonary oedema. Probably the chordae tendineae ruptured at that time and the rupture was related to the "wrecking ball" effect of the heavily calcified, mobile tumour. The sudden onset of mitral regurgitation suggested ruptured chordae tendineae but atrial myxoma was not considered.

A variety of auscultatory findings have been described in patients with left atrial myxoma, including systolic and diastolic apical murmurs, accentuated pulmonary valve closure sounds, ejection sounds and diastolic filling sounds (Goodwin, 1963; Greenwood, 1968; Harvey, 1968). The diastolic filling sound, the so-called "tumour plop," occurs earlier in diastole than the usual third heart sound, near the timing of the opening snap of the mitral valve with which it is sometimes confused (Greenwood, 1968; Abbott *et al.*, 1962; Pitt *et al.*, 1965). This early diastolic sound is thought to be produced by the sudden deceleration of the tumour on its pedicle as it enters the left ventricle (Pitt *et al.*, 1965). The "third heart sound" heard in our patient was quite early and may have been produced in this way. Though the combination of ruptured chordae tendineae and left atrial myxoma has not been previously reported the association should not be unexpected, especially when the tumour is calcified. While some mitral regurgitation can be caused by a left atrial myxoma, the sudden appearance of severe regurgitation would be unusual and misleading. The presence of an early third heart sound ("tumour plop") may be a clue in this situation, but it is difficult to distinguish from the usual third heart sound heard in some cases of mitral regurgitation.

The patient was referred to Dr. Peter M. Yurchak at the cardiac unit, Massachusetts General Hospital.

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Testicular Torsion in Henoch—Schonlein Syndrome

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The Henoch-Schönlein syndrome or anaphylactoid purpura is common in children. The presenting symptoms are non-thrombocytopenic purpura, arthralgia, abdominal pain, and sometimes renal abnormalities similar to those of poststreptococcal glomerulonephritis (Silber, 1972). Uncommon and atypical clinical presentations have been reported, including facial nerve palsy due to oedema and convulsions, and hemiparesis and coma due to hypertensive encephalopathy (Silber, 1972). Gastrointestinal complications have also been reported and include chronic gastrointestinal obstruction, perforation, massive haemorrhages, bowel necrosis, (Silber, 1972), and intussuception (Gairdner, 1968). Roy (1972) has reported a case of steatorrhoea and malabsorption complicating the Henoch-Schönlein syndrome. Fitzsimmons (1968) described two boys with testicular pain and scrotal swelling, a complication which had not been reported previously. Sahn and Swartz (1972) found testicular involvement in 38% of their 20 cases. We report an unusual complication of testicular involvement.

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Case Report

A 4½-year-old boy was admitted from the casualty department on 15 September 1973 with a painful swelling on the left side of the scrotum of four-hours duration. Haemorrhagic spots had appeared on both ankles on 12 September 1973, followed by

swelling of both ankle joints the next day. He complained of limping. At 16·00 hours on 15 September he developed sudden pain in the left side of the scrotum, which rapidly increased in severity. The purpuric rash now involved both lower extremities, the perineum, the suprapubic region, and both buttocks. The patient was the second of three boys in the family. He was born at full term, delivered normally, and the birth weight was 3·5 kg. There was no family history of any bleeding diathesis nor was there a history of bleeding or a similar episode of anaphylactoid purpura in this child.

The child was in severe pain from the obviously inflamed swelling on the left side of the scrotum. He was afebrile. A typical uticarial and purpuric rash with the distribution described together with arthralgia of both ankles suggested a diagnosis of Henoch-Schönlein syndrome. There were many purpuric spots on the scrotum particularly on the left side, which was swollen and looked inflamed. Both testes were palpable. The left testis was drawn-up and tense, felt enlarged, and was very tender. The right testis was normal. A diagnosis of Henoch-Schönlein syndrome with vasculitis of the left testis was made. In view of the clinical findings torsion of the left testis was suspected, and we decided to explore the scrotum.

At operation all the layers of the left testis were haemorrhagic and oedematous. It was considerably enlarged, blue, and congested due to the obvious torsion. The cyst of Morgagni was congested and haemorrhagic. Vasculitis was also present. The testis was untwisted and its colour returned to normal in a few minutes. It was then fixed in the usual manner. The right testis was not explored.

The patient was well postoperatively; the oedema in the scrotum disappeared and there was no increase in the extent of the purpuric rash or in the arthralgia. He remained well until 22 September 1973 when he had bloody diarrhoea with melaena and vomiting. The urine contained a few red blood cells but there was no other evidence of glomerulonephritis. He complained of severe pain in the abdomen. He responded to treatment and his symptoms quickly improved. On 26 September 1973 the haemoglobin was 12 g/100 ml; W.B.C., 11,600/mm^3; platelets 315,000/mm^3. He was symptomless and the urine and stools were negative for blood. When he was discharged on 7 October 1973 he had no purpuric rash or arthralgia, and the scrotum was normal.

Comment

This patient was admitted to hospital with the classical features of the Henoch-Schönlein syndrome, the rash and arthralgia appearing before the testicular involvement. There was no evidence of glomerulonephritis though the severity of the gastrointestinal lesion was shown by the bloody diarrhoea. Testicular involvement in the Henoch-Schönlein syndrome is uncommon despite an incidence of 38% in 20 cases reported by Sahn and Swartz (1972). Apart from these and the cases reported by Fitzsimmons, we know of only five other reported cases (Noussias, Blandy and Ward-McQuaid, 1969). None of the published cases of testicular involvement was complicated by testicular torsion, though some were surgically explored (Noussias, Blandy and Ward-McQuaid, 1969). Vasculitis and bleeding into the gastrointestinal tract is a common complication of the Henoch-Schönlein syndrome and presents with abdominal pain and sometimes bloody diarrhoea. Vasculitis in the gastrointestinal tract is rarely the site for an intussuception (Gairdner, 1948) and this can make diagnosis difficult as in this case, where vasculitis in the testis was complicated by testicular torsion. When testicular involvement occurs in the Henoch-Schölein syndrome vasculitis is undoubtedly the cause of the pain and swelling in the testis. In the present case oedema and haemorrhagic vasculitis were seen in the testis at operation. Vasculitis in the testis predisposes to testicular torsion just as vasculitis in the gastrointestinal tract predisposes to intussuception. Sahn and Schwartz (1972) thought surgical exploration unnecessary when testicular involvement complicates the Henoch-Schönlein syndrome. In view of the testicular torsion in this patient we recommend that it should be considered as a differential diagnosis and that surgical exploration should be carried out when there is testicular involvement.

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Unusual Presentation of Tuberculosis

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Unusual presentations of tuberculosis in the middle-aged and elderly are becoming more common, and yet in many cases the diagnosis is made only at necropsy. Often leucopenia is present, especially when the spleen is involved (Evans *et al.*, 1952; Fountain, 1954; Medd and Hayhoe, 1955; Cooper, 1959; Glasser *et al.*, 1970; Hansson *et al.*, 1972). The clinical condition is frequently diagnosed as either a malignant blood disease or a "connective-tissue disorder" and the patient treated with corticosteroids or cytostatic agents. In the present case of disseminated tuberculosis the clinical picture of arthralgia and fever and the presence of the L.E.-cell phenomenon and leucopenia led to a presumptive diagnosis of systemic lupus erythematosus (S.L.E.).

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Case Report

A 53-year-old man with fever of unknown origin and arthralgia was referred to us in May 1972. He had previously had excellent health, apart from a non-specific chorioretinitis diagnosed in 1965, and was seen regularly by his doctor. In January 1972 he suddenly developed arthralgia. In addition he had a slight, non-irritating rash on his chest, which lasted two weeks, and experienced temperatures of up to 39°C in the evenings. Antipyretics had no effect but the fever caused him little discomfort. During the six months before referral he had lost 5 kg in weight.

Physical examination showed nothing abnormal; in particular there was no enlargement of the lymph nodes, liver, or spleen and the skin was normal. Pulse rate 88/min; blood pressure 130/70 mm Hg; E.S.R. 99 mm in the first hour; packed cell volume 33%; W.B.C. 2,900/mm^3 (50% non-segmented neutrophils, 33·5% segmented neutrophils, 1·5% monocytes, 15% lymphocytes).