
Lymphedema of any region occurs whenever the total lymphatic outflow tract from a given part is incapable of clearing the proper amount of interstitial fluid and its protein load from the extravascular space. This paper describes the clinical management that essentially handles any type of lymphedema except that due to a completely obstructive or obliterative process. Satisfactory control of both primary and secondary lymphedema is often dependent upon the willingness of the physician to learn the management of the problem and to be aggressive enough in administering it and teaching the patient to accept the chronicity of the problem.


Several cases of isolated C2 deficiency in man have been reported in the medical literature. The earliest cases did not seem to be associated with known diseases or syndromes; more recently, reports of C2 deficiency associated with systemic lupus erythematosus; anaphylactoid purpura, recurrent infections, and dermatomyositis have appeared. Reported here is another case of C2 deficiency. The propositus, a 24-year-old woman, had a lupus erythematosus-like rash and a history of arthralgia, as well as a selective deficiency of C2. Studies of hemolytic C2 of the immediate members of her family indicate an autosomal-recessive mode of inheritance. These findings add to the increasing evidence that a C2 deficiency predisposes some persons to serious vascular diseases.


This paper discusses the various types of pacemakers available, the possible effects of electrosurgery on the pacemaker patient and suggestions to prevent mishap.
Abstracts


The diagnosis of skin lesions involves the same principles and methodology required in other medical problems. Visual recognition alone and "shotgun" therapy is not a satisfactory clinical approach. A disciplined and careful examination of lesions, establishment of a differential diagnosis, and selection of appropriate procedures are frequently necessary for cutaneous diseases. The indications, limitations, interpretation, and techniques of diagnostic procedures must be well understood to obtain reliable information. Not all tinea capitis will reveal fluorescence with Wood's light examination, but the Wood's light may be particularly helpful in the diagnosis of tinea versicolor, erythrasma, porphyria, and tuberculous sclerosis. Bacterial growth on cultures taken from the skin does not necessarily mean infection. Because the eczematous skin teems with bacteria, there must be a careful interpretation of the culture results within the context of the clinical situation. This paper is the first in a two-part series dealing with selected cutaneous procedures which are useful to the family physician in everyday practice.


The concentration of cephazolin in the serum, gall bladder bile, common duct bile, and gall bladder wall were considerably higher than cephalothin especially with IV administration and indicate that cephazolin should be a useful antibiotic in the surgical treatment of acute cholecystitis.


A linear form of porokeratosis, with features that we believe have not been previously described, is presented. The lesions occurred in a dermatome distribution; some of them had a central mass of parakeratotic keratin, shaped like a horn, which we designated a "giant cornoid lamella."


Blood pressure must be reduced within one hour in emergencies and within 24 hours in urgencies. A cautious yet aggressive lowering of blood pressure is indicated in patients with hemorrhagic stroke. Pheochromocytoma is a rare endocrine cause of hypertension, but it is life-threatening when sudden releases of catecholamines raises the blood pressure to critical levels. Retinal exudates and hemorrhages without papilledema indicate accelerated hypertension, which is relatively less progressive than malignant hypertension. Tables describe hypertensive emergencies and drugs used in emergencies and urgencies.


Four hundred and sixteen patients with documented arteriosclerotic heart disease (ASHD) underwent 424 diagnostic and therapeutic surgical procedures during the year 1970 at the Henry Ford Hospital. They were classified according to the specific clinical manifestation of their cardiac
Abstracts

abnormality. Patients with a history of old, well-compensated myocardial infarction, and those with cardiac arrhythmia, bundle-branch block, congestive heart failure and A-V block (pacemaker-protected) but no evidence of previous myocardial infarction fared almost as well as subjects of the same age without cardiac disease, and were considered to run the lowest operative risk. Patients with angina, especially if there was a history of infarction, were an intermediate risk in terms of complications and mortality. Patients with a history of previous infarction complicated at the time of the surgical procedure by arrhythmia, A-V block, bundle-branch block, or congestive heart failure were in the "highest risk" category. A severe A-V block indicated the need for insertion of a "prophylactic" pacemaker before any attempt at a diagnostic or therapeutic procedure. No patient with clinical or electrocardiographic evidence of a recent infarction (less than three months' duration) should undergo any elective surgical procedure under any form of anesthesia unless the surgeon is prepared for a high mortality rate that may approach 90%. In contrast, the patient with old, well-compensated myocardial infarction and no evidence of dysrhythmia, block or congestive failure can tolerate even a major surgical operation under any form of anesthesia extremely well.


Sixty-four women with Stage II breast cancer who had Sr" bone scans at the time of radical mastectomy were followed for 8 years in a prospective study. Those women with positive scans had a slight, but statistically significant, increased incidence of metastatic disease, particularly for metastases to bone. However, 40% of those women with positive bone scans and negative roentgenograms survived 8 years without evidence of any metastatic disease. Therefore, it has not been shown at this time that bone scans should be obtained in order to exclude bone metastasis before regional therapy for breast cancer is instituted. Also, a significant percentage of women with negative bone scans developed both bone and soft tissue metastases. As many as 30% of asymptomatic women with a history of breast cancer and positive bone scans and negative bone roentgenograms may still harbor disease in bone after 8 years.


To gain a better understanding of the pathogenesis, natural history, therapeutic response, and the potential of prevention of anastomotic aneurysms in general and those following aortofemoral interventions in particular, we have reviewed 4,214 reconstructive vascular operations performed in the past 15 years during which procedures (prosthetic bypass, autogenous vein graft, and endarterectomy) of fairly uniform technical details have been used. Among these operations representing 9,561 anastomotic sites, we encountered 205 anastomotic aneurysms, a per site incidence of 1.7 percent. By far the most common site of occurrence was the femoral artery following Dacron bypass procedures, with a per site incidence of 3.0 percent. The lowest rate of incidence was observed after endarterectomies, regardless of anatomic location (0.4 percent). The most frequent causative factor was found to be structural deficiency of the parent artery, which accounted for 30.7% percent of the aneurysmal lesions. Other etiological agents, in order of importance, were arterial hypertension, mechanical stress, defect of the graft material, and noninfective healing complications. The therapeutic approach was an aggressive one and only patients with prohibitive operative risks were treated conservatively. In the elective surgical cases the rate of good results was 81.6 percent, with no operative deaths.
Abstracts


Observations in 33 patients with congenital arteriovenous fistulas described ten years ago have been extended with the addition of 49 other cases; the clinical, pathologic, and roentgenographic characteristics of these lesions in the entire group of 82 patients have been summarized. The findings in the entire group over the additional observation period have confirmed the conclusions previously reached, namely, that (1) these clinically extremely varied lesions have a unitary (developmental) cause; (2) for rational management, angiographic investigation is indispensable to establish their extent and complexity; (3) with few exceptions, their radical cure by surgical means is impossible; and (4) the large majority of patients do well on a carefully supervised conservative regimen, with surgical intervention reserved for individually defined instances.

Listed by title:

**Antinuclear antibodies in lupus erythematosus.** T. K. Burnham. Letters to the editor, *Arch Dermatol* **112:**1329, 1976


Prolonging oxygen consumption during preservation of canine kidneys by the addition of continuous dialysis

Daniel Dall 'Olmo and Stanley G. Dienst, MD

A screening, referral, and follow-up program for high blood pressure at Henry Ford Hospital: Part II. Results of referral and follow-up

John C. Erfurt, BA; Andrea Foote, PhD, and John R. Caldwell, MD

Oral contraceptives and myocardial infarction

Mohsin Alam, MD; Remigio Garcia, MD, and Ellet H. Drake, MD

Penetrating abdominal trauma: A morbidity and mortality report of a growing social problem

F. Samhouri, MD; C. Grodsinsky, MD, and T. A. Fox, Jr., MD

Subvalvular aortic stenosis associated with dynamic outflow tract obstruction

Armando Cesar Madrazo, MD; Daniel T. Anbe, MD; James J. Karo, MD; Peter Torbey, MD; Ellet H. Drake, MD; Fareed Khaja, MD, and Sidney Goldstein, MD

Use of the Weibull distribution for analysis of a clinical therapeutic study in rheumatoid arthritis

W. R. McCrum, PhD; J. T. Sharp, MD, and G. B. Bluhm, MD

Publications of the staff—Titles and selected abstracts