

PROVA 1

- 1) L'importanza dei denti nelle analisi antropologiche
- 2) In che cosa consiste la rivoluzione di Vesalio
- 3) La tannizzazione
- 4) Utilizzo dei filtri in excel

PROVA 2

- 1) I marker occupazionali
- 2) Harvey e la scoperta della circolazione
- 3) Nuove tecnologie nella musealizzazione dei preparati anatomici
- 4) Inserimento piè di pagina in un word

PROVA 3

- 1) Cosa sono le transizioni epidemiologiche
- 2) L'importanza della scuola alessandrina
- 3) La ceroplastica nelle rappresentazioni museali
- 4) Inserimento di un grafico in excel

PROVA 4

- 1) La prima pandemia di sifilide in Europa
- 2) Cos'è la teoria umorale
- 3) La realtà aumentata nei percorsi museali
- 4) Le animazioni in power point

PROVA 5

- 1) Quali distretti ossei vengono colpiti dalla tubercolosi
- 2) Le innovazioni nel Canone di medicina
- 3) Questioni etiche legate all'esposizione di resti umani
- 4) Inserimento di una formula in excel

Chiara Stella

Grigoriy Bnata.

Ornella
Anna

PROVA 6

- 1) Tecniche di ricostruzione 3D in paleopatologia
- 2) Il metodo morgagnano
- 3) Questioni etiche legate alla conservazione di resti umani
- 4) Gestione delle immagini in power point

PROVA 7

- 1) Il vaiolo in Italia
- 2) La scoperta della circolazione polmonare
- 3) Problematiche legate alla conservazione in liquido dei reperti anatomici
- 4) Inserimento di un video in un power point

PROVA 8

- 1) La paleopatologia delle mummie
- 2) La medicina quantitativa di Santorio
- 3) Quali strategie adottare per la didattica museale delle collezioni anatomiche
- 4) Impostare il layout di pagina in word

PROVA 9

- 1) Interventi chirurgici in paleopatologia
- 2) Fracastoro e la sifilide
- 3) Tecnologie per percorsi per ipovedenti
- 4) Ordinamento di celle in excel

PROVA 10

- 1) La pratica della trapanazione cranica
- 2) Il metodo quodlibetario
- 3) Quali sono le principali tecniche utilizzate nel restauro di reperti anatomici
- 4) Creazione di una tabella in word

Luca Costantini

Gioyia Brucchi

Gene B...

Marina

CASE RECORDS OF THE MASSACHUSETTS GENERAL HOSPITAL

Founded by Richard C. Cabot, Eric S. Rosenthal, M.D., Editor, Virginia M. Pierce, M.D., David M. Dudzinski, M.D., Meridale V. Baggett, M.D., Dennis C. Sgroi, M.D., Jo-Anne O. Shepard, M.D., Associate Editors, Kathy M. Tran, M.D., Case Records Editorial Fellow, Emily K. McDonald, Tara Cooney, Production Editors



Case 17-2020: A 68-Year-Old Man with Covid-19 and Acute Kidney Injury

Meghan E. Sise, M.D., Meridale V. Baggett, M.D., Jo-Anne O. Shepard, M.D., Jacob S. Stevens, M.D., and Eugene P. Rhee, M.D.

PRESENTATION OF CASE

Dr. Meridale V. Baggett: A 68-year-old man was admitted to this hospital with fever, shortness of breath, and acute kidney injury during the pandemic of coronavirus disease 2019 (Covid-19), the disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

The patient had been in his usual state of health until 4 days before admission, when fever developed, with a temperature of up to 39.9°C and associated shaking chills. He had a poor appetite and was eating and drinking less than usual. Three days before admission, he stopped using long-acting insulin for his diabetes because fasting blood glucose levels were less than 100 mg per deciliter (5.6 mmol per liter; reference range, 70 to 99 mg per deciliter [3.9 to 5.5 mmol per liter]). One day before admission, a dry cough developed. On the morning of admission, the patient noticed shortness of breath. He called his primary care physician, who recommended that he present to the emergency department of this hospital for further evaluation.

In the emergency department, the patient reported ongoing shortness of breath, with no chest pain, orthopnea, or leg swelling. He had not traveled recently. He worked as a limousine driver but had not had known contact with anyone with confirmed SARS-CoV-2 infection.

The patient had a history of diabetes, hypertension, hyperlipidemia, coronary artery disease, obesity, and obstructive sleep apnea. A drug-eluting stent had been placed in the left anterior descending coronary artery 7 years earlier. Medications included aspirin, clopidogrel, dulaglutide, empagliflozin, ezetimibe, glipizide, insulin glargine, lisinopril, metformin, metoprolol, rosuvastatin, and testosterone. There were no known drug allergies. The patient did not smoke, drink alcohol, or use illicit substances. He lived with his girlfriend in a suburb of Boston. His family history included coronary artery disease in his father and emphysema in his mother.

A

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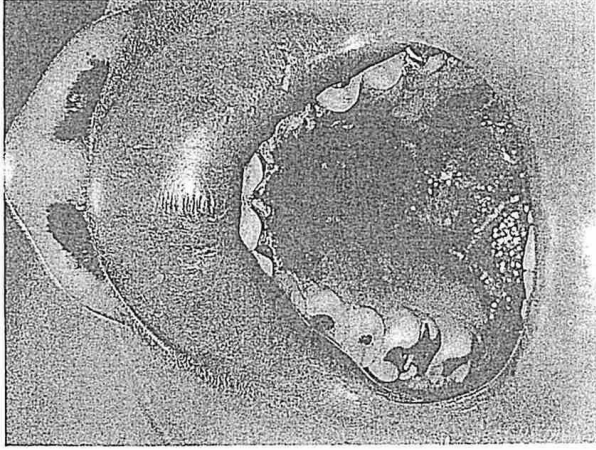
This case was published on May 11, 2020, at NEJM.org.

NEJM J Med 2020;382:21-47. DOI: 10.1056/NEJMc1915151 Copyright © 2020 Massachusetts Medical Society.

IMAGES IN CLINICAL MEDICINE

Chana A. Sacks, M.D., Editor

Palatal Ulceration



Meng-Han Shen, M.D., Ming-Ying Wu, M.D.

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A 50-YEAR-OLD WOMAN PRESENTED TO THE DERMATOLOGY CLINIC WITH A PAINLESS ULCER ON HER PALATE and a swollen lip, which were associated with intermittent fevers and general malaise. She had a 3-year history of nasal obstruction with purulent discharge, for which she had received treatment with intranasal glucocorticoids and antibiotic agents. Physical examination revealed a large ulcer with a necrotic base extending over the soft and hard palates. Surrounding erosions covered with fibrinoid exudate were noted, in addition to a swollen upper lip and discolored nasal discharge. The results of laboratory studies showed a white-cell count of 2200 per cubic millimeter (reference range, 4500 to 11,000), a hemoglobin level of 10.7 g per deciliter (reference range, 12 to 15), a platelet count of 65,000 per cubic millimeter (reference range, 150,000 to 400,000), and a ferritin level of 38,745 ng per milliliter (reference range, 12 to 263). Histopathological analysis of a biopsy specimen showed lymphoid proliferation with positive staining for CD3, CD56, and granzyme B, and Epstein-Barr virus was detected on in situ hybridization. A diagnosis of extranodal natural killer T-cell lymphoma, nasal type, was made. A bone marrow biopsy revealed evidence of hemophagocytosis, which is associated with this disease. Chemotherapy was initiated, however, the patient died 1 month later.

DOI: 10.1056/NEJMc1915151 Copyright © 2020 Massachusetts Medical Society.

Handwritten signatures: Shen, Wu, and a large signature.

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Case 24-2020: A 44-Year-Old Woman with Chest Pain, Dyspnea, and Shock

Christopher Newton-Cheh, M.D., M.P.H., Daniel A. Zlotoff, M.D., Ph.D.,
Judy Hung, M.D., Andrey Rupasov, M.D., Jerome C. Crowley, M.D.,
and Masaki Funamoto, M.D., Ph.D.

PRESENTATION OF CASE

Dr. Daniel A. Zlotoff: A 44-year-old woman was admitted to this hospital because of shortness of breath and chest pain.

Eight days before admission—and 3 days after her husband had begun to have fatigue, a nonproductive cough, and a fever—and the patient started to have chills, a sore throat, a nonproductive cough, and myalgias. After 2 days of progressive symptoms, she contacted her primary care physician. A telemedicine visit was arranged as part of a local public health strategy to reduce the spread of coronavirus disease 2019 (Covid-19), the disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), during the pandemic. The patient reported that she had rib soreness with coughing, as well as a temperature of 35.3°C. Infection with SARS-CoV-2 was suspected. Rest, isolation measures to reduce viral transmission, and increased oral intake of fluid were recommended, along with acetaminophen and dextromethorphan-guaifenesin as needed. Three days later, she had diarrhea and back pain, but the coughing had become less frequent. During a follow-up telemedicine visit, the primary care physician recommended that the patient take acetaminophen as needed for back pain and counseled her to seek in-person medical evaluation if symptoms worsened.

Three days later, the patient started to have chest pain that was different from the rib soreness with coughing; the chest pain was present at rest and was accompanied by new dyspnea. She called emergency medical services. On the initial evaluation, the heart rate was 116 beats per minute, the systolic blood pressure 110 mm Hg, the respiratory rate 20 breaths per minute, and the oxygen saturation 99% while she was breathing ambient air. The patient was brought by ambulance to the emergency department of this hospital.

On arrival, the patient reported feeling weak, light-headed, and feverish, with chills. She reported that the chest discomfort felt like pressure, was primarily located in the anterior chest, and was mild in intensity but worsened with deep inspiration or coughing. She also reported nausea and a few episodes of nonbloody diarrhea.

Anna

Jordan Costello

Alayshbrook

CASE RECORDS of the MASSACHUSETTS GENERAL HOSPITAL

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Production Editors



Case 22-2020: A 62-Year-Old Woman with Early Breast Cancer during the Covid-19 Pandemic

Laura M. Spring, M.D., Michelle C. Specht, M.D., Rachel B. Jimenez, M.D.,
Steven J. Isakoff, M.D., Ph.D., Gary X. Wang, M.D., Ph.D., Amy Ly, M.D.,
Jennifer A. Shin, M.D., M.P.H., Aditya Bardia, M.B., B.S., M.P.H.,
and Beverly Moy, M.D., M.P.H.

PRESENTATION OF CASE

Dr. Aditya Bardia: A 62-year-old woman was evaluated at this hospital after she had identified a mass in her left breast, confirmed by her physician on physical examination, during the pandemic of coronavirus disease 2019 (Covid-19), the disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

The patient, who was of Ashkenazi Jewish ancestry, had no known family history of breast or ovarian cancer. Medical history included asthma and a fibroadenoma in the left breast, for which she had undergone excisional biopsy 30 years earlier. Menarche had occurred at 12 years of age and menopause at 54 years of age; she had not received hormone-replacement therapy.

Physical examination revealed a mass, measuring 3 cm in greatest dimension, in the left breast. No other masses or axillary lymph nodes were palpable. The patient underwent imaging studies in accordance with the American College of Radiology guidelines.¹ Both breasts were imaged, since the patient's last mammogram had been obtained 7 years earlier.

Dr. Gary X. Wang: Mammography revealed an irregular mass with spiculated margins underlying the skin marker in the left breast, with imaging characteristics highly suggestive of cancer (Fig. 1A, 1B, and 1C).² Subsequent ultrasound examination revealed a solid, irregular mass in the left breast that measured 3.1 cm by 1.5 cm by 1.2 cm (Fig. 1D) and normal left axillary lymph nodes. Tissue sampling with core-needle biopsy under ultrasonographic guidance was performed (Fig. 1E).

PATHOLOGICAL DISCUSSION

Dr. Amy Ly: Histologic evaluation of the biopsy specimen revealed invasive ductal carcinoma, grade 2, spanning at least 1.6 cm in greatest dimension. No definitive lymphovascular invasion or cateinoma in situ was identified (Fig. 2A). Immuno-

CASE RECORDS of the MASSACHUSETTS GENERAL HOSPITAL

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Case 23-2020: A 76-Year-Old Woman Who Died from Covid-19

James R. Stone, M.D., Ph.D., Kathy M. Tran, M.D., John Conklin, M.D.,
 and Mari Mino-Kenudson, M.D.

PRESENTATION OF CASE

Dr. Kathy M. Tran: A 76-year-old woman was admitted to this hospital because of confusion and hypoxemia during the pandemic of coronavirus disease 2019 (Covid-19), the disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

The patient had been well until 6 days before this admission, when nasal congestion developed, with no fever or cough. One day before this admission, she called her primary care physician, who recommended fluticasone nasal spray and nasal rinses and asked her to follow up by telephone in 2 days. However, the next day, the patient's son visited the patient and found her to be confused and incontinent of urine and stool. Emergency medical services were called, and when they arrived at the patient's home, the oxygen saturation was 87% while she was breathing ambient air. The patient was transported by ambulance to this hospital.

In the emergency department, the patient reported chills but no fever, cough, shortness of breath, sore throat, chest pain, or dysuria. Additional information was obtained from the patient's daughter and son by telephone. There was a history of asthma, diabetes, hypertension, hyperlipidemia, osteoporosis, and psoriasis. Medications included atorvastatin, aspirin, hydrochlorothiazide, losartan, insulin, metformin, glipizide, citalopram, acetaminophen, cholecalciferol, folate, fluticasone nasal spray, and topical betamethasone and fluocinonide. Lisinopril had caused a cough, penicillin and sulfa drugs had caused hives. The patient was widowed and lived in an assisted-living facility where multiple residents had recently received a diagnosis of Covid-19. She did not smoke tobacco or use electronic cigarettes, alcohol, or illicit drugs. Her family history included diabetes and cancer in both her father and her brother; her daughter and son were well.

The temperature was 38.8°C, the heart rate 94 beats per minute, the blood pressure 176/95 mm Hg, the respiratory rate 24 breaths per minute, and the oxygen saturation 94% while the patient was receiving supplemental oxygen through a nasal cannula at a rate of 2 liters per minute. On examination, the patient appeared ill and was lethargic. She was alert and oriented but unable to recall events

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N Engl J Med 2020;383:380-7.
 DOI:10.1056/NEJMc2004974
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Oborn

John Costello

Calypso

REVIEW ARTICLE

Edward W. Campion, M.D., Editor

Coffee, Caffeine, and Health

Rob M. van Dam, Ph.D., Frank B. Hu, M.D., Ph.D.,
 and Walter C. Willett, M.D., Dr.P.H.

COFFEE AND TEA ARE AMONG THE MOST POPULAR BEVERAGES WORLDWIDE and contain substantial amounts of caffeine, making caffeine the most widely consumed psychoactive agent.¹ A variety of plants contain caffeine in their seeds, fruits, and leaves. Besides coffee and tea, these plants include cacao beans (an ingredient of chocolate), yerba mate leaves (used to make an herbal tea), and guarana berries (used in various beverages and supplements).^{1,2} Caffeine can also be synthesized and is added to foods and beverages, including soft drinks, energy drinks, and energy shots, and to tablets marketed for reducing fatigue.² In addition, caffeine is widely used as a treatment for apnea of prematurity in infants,³ and caffeine and analgesic agents are used together in pain medications.⁴

Coffee and tea have been consumed for hundreds of years and have become an important part of cultural traditions and social life.⁵ In addition, people use coffee beverages to increase wakefulness and work productivity. The caffeine content of commonly used sources of caffeine is shown in Table 1. For a typical serving, the caffeine content is highest in coffee, energy drinks, and caffeine tablets; intermediate in tea; and lowest in soft drinks. In the United States, 85% of adults consume caffeine daily,⁶ and average caffeine intake is 135 mg per day, which is equivalent to about 1.5 standard cups of coffee (with a standard cup defined as 8 fluid oz [235 ml]).⁷ Coffee is the predominant source of caffeine ingested by adults, whereas soft drinks and tea are more important sources of caffeine ingested by adolescents (Fig. 1).

Concerns have long existed that coffee and caffeine may increase the risks of cancer and cardiovascular diseases, but more recently, evidence of health benefits has also emerged.⁸ A key issue in research on caffeine and coffee is that coffee contains hundreds of other biologically active phytochemicals, including polyphenols such as chlorogenic acid and lignans, the alkaloid trigonelline, melanoidins formed during roasting, and modest amounts of magnesium, potassium, and vitamin B₃ (niacin).⁹ These coffee compounds may reduce oxidative stress,⁹ improve the gut microbiome,¹⁰ and modulate glucose and fat metabolism.^{11,12} In contrast, the diterpene cafestol, which is present in unfiltered coffee, increases serum cholesterol levels.¹³ Thus, research findings for coffee and other dietary sources of caffeine should be interpreted cautiously, since effects may not be due to caffeine itself.

METABOLISM, PHYSIOLOGICAL EFFECTS, AND TOXIC EFFECTS
 ABSORPTION AND METABOLISM

Chemically, caffeine is a methylxanthine (1,3,7-trimethylxanthine). Caffeine absorption is nearly complete within 45 minutes after ingestion, with caffeine blood

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N Engl J Med 2020;383:369-78.
 DOI:10.1056/NEJMj201816604
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Case Report

An autopsy case of pulmonary artery intimal sarcoma: detailed observation of tumor and its related lesions in pulmonary arteries^{☆,☆☆}

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ARTICLE INFO

Article history:
Received 19 May 2019
Received in revised form
3 July 2019
Accepted 12 July 2019

Keywords:
Pulmonary artery
Intimal sarcoma
Undifferentiated pleomorphic sarcoma
Sudden death
Autopsy

ABSTRACT

We report an autopsy-proven case of a 33-year-old man who died of intimal sarcoma of the pulmonary artery. A large mass (5×4 cm) occluded the main and bilateral pulmonary arteries. Tumor cell morphology was consistent with that of undifferentiated pleomorphic sarcoma. Comprehensive histological observation of 18 pulmonary arteries from proximal to distal revealed continuous extension of the tumor from the main to the subsegmental arteries along the intima, forming an arteriosclerosis-like intimal thickening. Distal small arteries were also affected by eccentric intimal thickening or recanalization. Lung parenchyma was not involved, although there were two wedge-shaped small pulmonary infarctions caused by tumorous obstruction of the associated arteries. Histological results indicated that the intimal sarcoma in the pulmonary artery, which appeared occlusive with growth limited to the proximal artery, had in fact already spread more peripherally than expected. Both the proximal lesions and the distal small arteries were affected by peripheral tumor emboli or by pulmonary hypertension induced by the proximal tumor. However, as seen in this case, most of the proximal tumor was located locally and intraluminally, in the proximal artery, and removing the proximal tumor by pulmonary endarterectomy was considered effective for symptomatic improvement.

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1. Introduction

Pulmonary artery intimal sarcoma (PAIS) is an extremely rare malignant tumor, with only approximately 500 cases reported to date [1]. Because PAIS has the characteristic growth pattern arising at the proximal pulmonary artery and developing intraluminally [2], it is usually misdiagnosed as chronic thromboembolic pulmonary hypertension (CTEPH) [3,4]. The small number of published case reports includes autopsy cases [5,6] because of the high mortality rate of this tumor [1]. However, previous autopsy reports focused on the proximal large tumor, with little information regarding the distal lesions in the pulmonary arteries. We experienced a case of sudden death in a young man with undiagnosed

[☆] Declarations of interest: none.

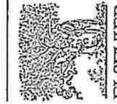
^{☆☆} Funding: none.

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https://doi.org/10.1016/j.carpath.2019.07.002

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Original Article

Syphilitic aortitis: still a current common cause of aneurysm of the tubular portion of ascending aorta

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ARTICLE INFO

Article history:
Received 24 September 2019
Received in revised form
16 October 2019
Accepted 22 October 2019

Keywords:
Aortic aneurysm
Aortic syphilis
Aortitis
Aortic regurgitation

ABSTRACT

Aortic syphilis today is infrequently diagnosed clinically. Described herein are findings in 5 women who had resection of a fusiform aneurysm of the tubular portion of ascending aorta, and examination of the wall of the aneurysm disclosed classic features of aortic syphilis. The 5 patients were among 36 who had ascending aortic operations at Baylor University Medical Center in Dallas in 2018 and early 2019. Syphilitic aneurysm in each spared the sinus portion and involved diffusely the tubular portion of ascending aorta, beginning at the sinotubular junction. The aneurysmal wall was thicker than normal because of thickening of both intima and adventitia. The latter contained foci of lymphocytes and plasma cells and thickened and narrowed vasa vasora. The media was disrupted by fibrous scars, which weakened the integrity of the aorta. Aortitis of the tubular portion of ascending aorta in syphilis is a diffuse process, but often is mistakenly called “atherosclerosis” which, when present in this portion of aorta, can be extensive but is focal. Aortic syphilis is important to diagnose so that patients can receive antibiotic therapy to delay, prevent, or treat neurosyphilis, a common accompaniment of aortic syphilis.

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1. Introduction

In recent years, several articles have appeared describing classic gross and histologic features of syphilis of the aorta and they have emphasized its role as a common cause of fusiform and sacular aneurysms of the ascending aorta [1–6]. Despite these publications, patients with chronic aneurysms of the tubular portion of ascending aorta continue to be treated without consideration that the aneurysm may be the result of syphilis: a serologic test for syphilis is not performed; the resected aorta submitted to surgical pathology is not diagnosed as aortic syphilis, and most of these patients never receive appropriate antibiotic therapy to delay, prevent, or treat the occurrence of neurobiological syphilis. This report simply adds to previous ones to emphasize that aortic syphilis is indeed back, needs to be properly diagnosed, and requires appropriate antibiotic therapy.

2. Materials and methods

This report describes pertinent clinical and morphologic findings in five women, who underwent operative resection of a fusiform aneurysm of the tubular portion of ascending aorta at Baylor University Medical Center (BUMC) during 2018 and the first 2 months of 2019, and histologic study of the aneurysmal wall showed classic features of aortic syphilis. These five patients were among 43 patients who underwent resection of all or a portion of the tubular portion of ascending aorta at BUMC in 2018 and early

Table 1
Resection of ascending aortic aneurysm at the Baylor University Medical Center (January 2018–February 2019) (14 months)

Causes	Number of cases
Aortic dissection	23 (58%)
Associated with a unicuspid or bicuspid aortic valve	9 (22%)
Associated with purely regurgitant aortic valve	3 (8%)
Secondary to probable systemic hypertension (2 patients)	
or sinus of Valsalva aneurysm (1 patient)	
Syphilis	5 (12%)
Total	40

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https://doi.org/10.1016/j.carpath.2019.10.0175

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