

Acknowledgement

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Congenital Subclavian Artery Aneurysm

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It is usually assumed that if an aneurysm appears at an early age and if there is no history of trauma, systemic infection or presence of atherosclerosis, it must have developed due to some inherent weakness of the arterial wall(1). The term "congenital" aneurysm is obviously a misnomer, since it is the arterial wall weakness rather than aneurysm itself that is present at birth. It is often difficult in such aneurysms to identify the responsible congenital factor. We are reporting a case in which a congenital left subclavian artery aneurysm was diagnosed in a 11-month old child. No similar case appears to have been reported previously at this age.

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Case Report

An 11-month-old boy, presented with dry cough for last 2 months which was not responding to treatment. Physical examination revealed a healthy male child with normal milestones. The pulse was 88 per minute and had normal temperature. Blood pressure at the level of the brachial artery was 110/80 mm Hg on both sides. All the pulses were normal bilaterally. Systemic examination did not reveal any abnormality. Laboratory studies were not remarkable; including negative serological tests for syphilis. X-ray chest demonstrated a well-defined superior mediastinal mass on right side without calcification. On fluoroscopy, the mass was nonpulsatile. CT scan showed an enhancing mass with peripheral low attenuation area suggestive of a thrombosed aneurysm. Digital subtraction angiography revealed its origin from left subclavian artery confirming the diagnosis of a large aneurysm from the left subclavian artery.

At surgery a large aneurysm measuring about 7.5 cm in diameter occupying apical region of left hemithorax was seen arising from left subclavian artery. There were a lot of lamellar clots in the aneurysmal sac which were evacuated after incising it. The aneurysmal sac was plicated. The patient had a rapid and uneventful recovery.

Discussion

Arterial aneurysms other than those of the aorta are uncommon and seldom occur in upper extremity, less than 5% of peripheral arterial aneurysms are located in upper extremity(1) and at least 75% of them are atherosclerotic or post-traumatic in origin. Most of the remainders are ineffective (mycotic) or post-inflammatory (arteritic) aneurysms(2). Congenital aneurysms are uncommon except in the circle of

Willis. Congenital aneurysms of subclavian artery at any age are rare and in children exceedingly rare(1).

Congenital anomalies of the origin of the great vessels from the aorta are associated with an increased incidence of aneurysm. Aberrant retroesophageal right subclavian arteries show a greater tendency to aneurysm formation(3). Many reports have attributed aneurysms of the subclavian artery to post stenotic dilatation associated with cervical ribs(4). However, cases of idiopathic arterial aneurysms have been described(5).

Patients of subclavian artery aneurysms may present with a pulsatile supraclavicular swelling or with upper chest pain. Ischemia of the upper extremity secondary to thrombotic occlusion of the subclavian aneurysms have been reported(6). However many of the patients are asymptomatic. Our patient who was 11-month-old presented with cough which could be due to compression of the lung.

In cases of intrathoracic subclavian arterial aneurysms chest roentgenogram will reveal a pulsatile superior mediastinal mass. In our case the chest X-ray revealed a well defined, noncalcified superior mediastinal mass (*Fig. 1*).

CT is very useful for assessment of mediastinal masses. It is ideal for assessment of vascular lesions. The maximum transverse diameter of aneurysms, calcifications, mural thrombus, perianeurysmal inflammation can be easily identified by CT(7). In our case a thrombosed aneurysm was diagnosed by CT scan (*Fig. 2*) but due to its large size its precise origin from the vessel could not be confirmed. Hence, a DSA was done which demonstrated its origin from left subclavian artery (*Fig. 3*).

A few of the congenital aneurysms are known to be due to defects in connective

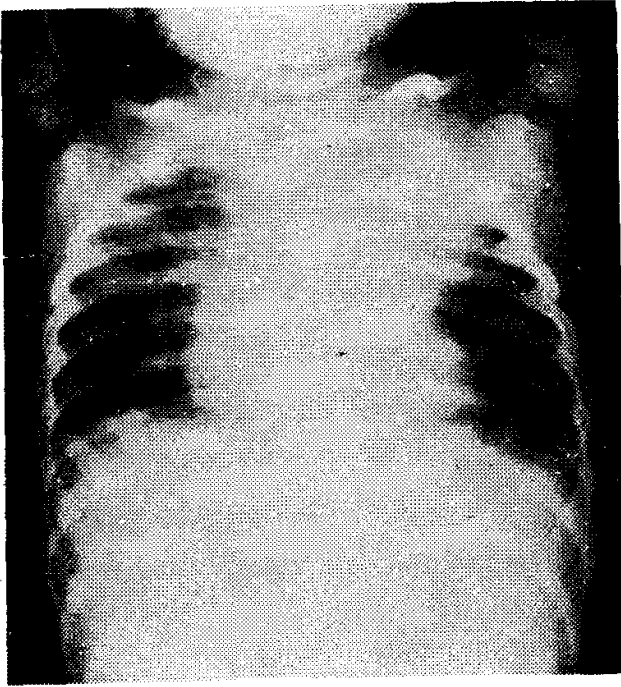


Fig. 1. X-ray chest showing a mass lesion in the left upper zone.

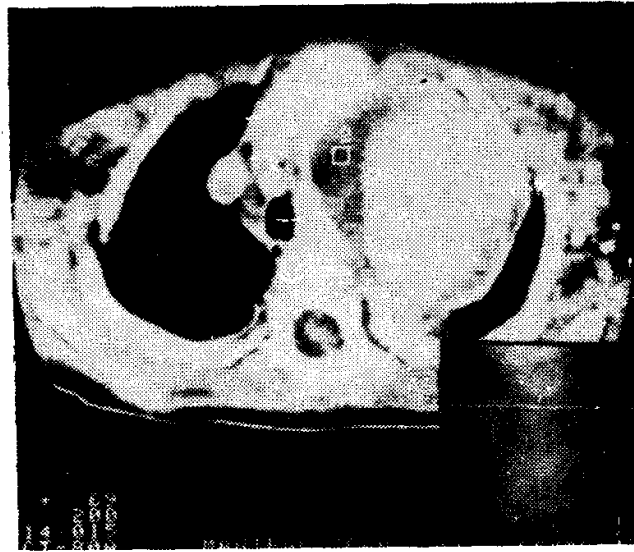


Fig. 2. Post contrast CT scan of the mass demonstrating a large uniform densely enhancing area with a peripheral hypodense rim suggestive of giant thrombosed aneurysm.

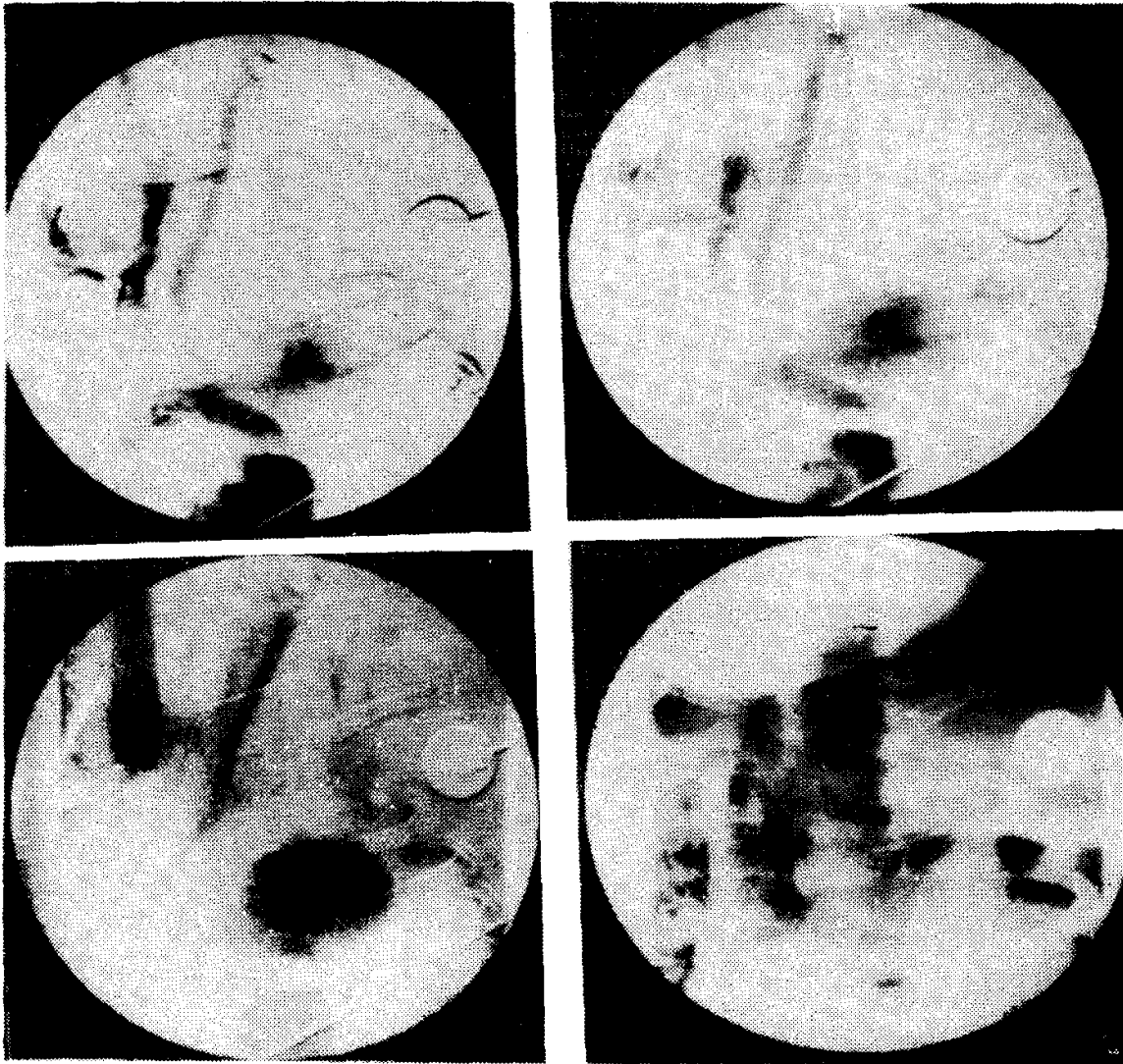


Fig. 3. Intravenous DSA demonstrating the aneurysmal sac arising from left subclavian artery.

tissue as in case of Ehlers-Danlos syndrome or Marfan's syndrome. But all of them cannot be explained on the basis of known defects in connective tissue. Although some as yet unrecognized inherited defect in the connective tissue may be responsible for some, the others are probably due to either unrecognized trauma or inflammatory disease. This or some other form of focal arteritis could weaken the arterial wall sufficiently to result in aneurysm formation. Hence, it is not possible in all cases to define the exact cause of aneurysm formation. Our case also belongs to this group in which exact etiological factor responsible for aneurysm formation could not be traced.

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Starvation—A Rare Cause of Intussusception in Preadolescence

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Although an extremely uncommon variety of idiopathic intussusception in adults immediately after the Mohammedan fasting seasons has been reported earlier(1), starvation has seldom been recognised as a cause of intussusception in children. A plausible explanation of intussusception due to starvation has been given on the basis of 'hyperperistalsis', a physiological factor which has not been well emphasized before in the etiopathogenesis of intussusception.

Case Report

A 12-year-old Mohammedan boy was admitted with sudden onset of abdominal pain followed by bilious vomiting and obstipation during the observance of fasting on the fourth day of the 'Ramzan' month. Clinical examination revealed a sausage shaped mass in the para-umbilical

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