Postoperative granulomas are generally considered to be asymptomatic. They are, however, important in other ways. Firstly, they may raise the possibility in the pathologist’s mind of previous surgery, and secondly, they should not be confused with other granulomatous diseases including tuberculosis, which would precipitate further unnecessary investigation and treatment. Their occurrence in the urinary and female genital tracts may reflect both the use of diathermy and the incidence of second operations in these areas, but it seems likely that necrobiotic granulomata will be found in other sites where there has also been previous surgery.

GE WILSON
NY HABOURI
LJ MCMILLIAM
PJ HIRSCH
Departments of Histopathology
and Obstetrics and Gynaecology,
University Hospital of South Manchester,
West Didsbury, Manchester M20 8LR

Traumatic aneurysm of the left common carotid artery

Traumatic aneurysms of the major branches of the aortic arch are relatively uncommon, but those of the left common carotid artery are rare indeed, there being only four cases reported to date. We present a case of traumatic aneurysm at this site and suggest a mechanism of production.

A 40 year old man collided with a car while riding a motor cycle and was admitted to hospital in a haemodynamically stable condition, but in deep coma with a large bruise on the left shoulder. A computed tomogram of the head showed generalised cerebral oedema and haemorrhagic bifrontal contusions. A chest x-ray picture showed cupping of the left lung apex with blood, and emergency arch aortography showed a false aneurysm of about 2 x 3 cm at the origin of the left common carotid artery with slight flow delay up that vessel. As repair of this lesion would have required aortic arch clamping a conservative approach was adopted due to the patient’s poor neurological state which did not improve. The patient died seven months later.

Pathology

At necropsy there were numerous established wedge shaped areas of infarction affecting the cortex as well as white matter in the left internal carotid arterial territory associated with old organised emboli in the branches of

Figure 1  The aneurysm of the left common carotid artery was identified at the lesion (A) arising from a disruption in the vessel wall (X) of the normal left common carotid artery.

direct blow to the anterior triangle of the neck; (2) a glancing blow to the head, hyperextending, rotating and laterally flexing the neck away from the side of the lesion causing the carotid to be carried upward and backward, stretching it over the transverse process of the third cervical vertebra; (3) blunt intraoral trauma; (4) basal skull fractures causing occlusion in the petrous portion.

Why the aneurysm occurred at the origin and not the bifurcation of the vessel is not clear. Congenital medial weakness may have played a part but this is not a tenable hypothesis in the light of the microscopic evidence which clearly showed all layers of the arterial wall to be normal. The hyperextension, rotation, and lateral flexion of the neck, thereby distracting the carotid artery, combined with counter traction on the aortic arch via the left subclavian artery, may have produced the localised forces necessary to disrupt the arterial wall at this rare site. Evidence that such forces occurred at the time of injury is provided for carotid distraction by the histological findings consistent with an old rotatory injury, and for subclavian artery traction by the presence of the large bruise noted on the patient’s left shoulder.

FG JOHNSTON
A WATERS
GA GRESHAM
Departments of Neurosurgery and Histopathology,
Addenbrooke’s Hospital, Hills Road, Cambridge

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