

A CASE OF MENINGEAL TUMORS OF THE PRE-FRONTAL REGION—LATE PULMONARY TUBERCULOSIS—HISTORY OF SYPHILIS.¹

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THE following case presents several points of special interest. The most important are the mental symptoms, such as slow cerebration, caused by a frontal lesion, and the prompt detection of commencing pulmonary tuberculosis. This complication was held to be a good reason for abandoning a trephining operation, which had been determined upon and which would have been successful, probably, in reaching one of the tumors.

R. H., 32 years old, colored, a waiter by occupation, single, was admitted to the Philadelphia Hospital, March 6, 1891. Five years before admission he contracted syphilis, and three years later he had a fit for the first time. He did not lose consciousness in this attack, but he was not able to describe the fit. During the summer of 1890 he had constant headache, which was not localized and which was relieved somewhat by treatment.

The patient when admitted had a swelling of the soft tissues of the brow and eyelid of the right side, with a slight prominence of the eyeball. No paralysis of the third, fourth, or other cranial nerve was observed. Nystagmus was not noted. Lachrymation was excessive. The swollen parts were so painful that the man would not allow manipulation of them. He said that the swelling had been present since the previous Christmas. He complained of much pain in both shoulders. He was not paralyzed in any limb. His heart and lungs were normal. His mind was dull. He cerebrated slowly and did not make known his wants, and unless spoken to he did not speak.

The most characteristic symptom was this slow cerebration. In view of the location of the lesion in the pre-frontal region this had special significance. It was peculiar.

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The patient seemed to comprehend the question and yet did not answer it for a long period, and not until he had been urged repeatedly. It looked at first like obstinacy, and was so judged by some who saw the case. When the answer came it was correct, but given in few words. This retardation in the time-reaction was estimated at its true value in my original study of the case. I judged it to be pathological and significant of a frontal lesion. The man did not exhibit, however, the irritable and violent character which has been noted by some in lesions of the frontal lobe. Yet his actions were similar to the automatic or reflex movements seen in some of these cases. This was shown especially by his total disregard of time and place in passing his urine and fæces.

Later the superior rectus muscle became apparently parietic, but it was so in appearance only, as the eyeball was held down by the swelling. Although at times there appeared to be some strabismus, it was difficult to tell what muscles were involved. These symptoms were caused probably by œdema of the tissues. Nystagmus was now present. Hyperæsthesia over the forepart of the head, even on the left side, was noted. The temperature, pulse and respiration were normal for the first six weeks, during which time the patient's mental condition did not improve. Muscular rigidity was noted a few times. The knee-jerk was abolished. He passed his urine and fæces in bed. When remonstrated with for his unclean habit, he seemed to be perfectly rational, and to understand what was said to him, but the habit continued because, apparently, of his inability to fix his attention and to respond to sensory impressions. The lower centres acted automatically or reflexly.

On careful inquiry the patient denied any injury. The swelling was crepitant. No alteration of the bone could be detected because of the swelling and pain.

The man continued to have quite frequent fits (several a week). The nurse reported that in one of these the mouth was drawn to the left; consciousness was quite abolished. After the fit the right knee-jerk was much freer than the left. The hyperæsthesia about the eye could be demonstrated even in the post-epileptic stupor. An eye examination at this time by Dr. Gould gave negative results.

The patient left the hospital, and was gone about a month.

When he returned, in June, exophthalmos and swelling about the eye had diminished, but a painful, soft, fluctu-

ating swelling was present over the right frontal eminence. The mental condition had so much improved that it was about normal. He still had an occasional involuntary urination at night, and more rarely an involuntary stool.

At this time, three months after the patient's first admission, the swelling was opened and drained by Dr. F. S. Janney, the resident physician. It contained pus and caseous material. It healed well, and gave no further trouble; but the scalp remained slightly tender at that point.

About one month later the man's temperature was found to be ranging high at night. Physical examination revealed a few moist râles at the apex of the right lung in front, and dry râles high up in the interscapular region. He had no convulsion for more than one month after draining the scalp abscess.

On July 15th, in consultation with Drs. Mills, Sinkler, Dercum and Deaver, of the hospital staff, trephining was decided upon; but one week later the idea of operation was abandoned, because the indications of commencing tubercular disease of the lungs had become still more marked. Careful examination again showed bubbling râles at both apices, most marked on the right, and sibilant râles between the scapulæ. The resonance was impaired over the upper part of each lung. The urine showed a trace of albumen.

The disease advanced rapidly. Expectoration was always scanty. The symptoms of brain disorder continued about the same. The patient had an occasional fit, the character of which was not noted. He was very slow in his movements. His lungs seemed to clear up after a convulsion—that is, he had fewer moist râles. This was attributed to the deep and labored respiration seen usually toward the end of an epileptic paroxysm.

In July an examination of the eyes was made by Dr. de Schweinitz, with negative results.

Up to the time of death, which occurred in October, the symptoms were those of a rapidly declining phthisical patient, the temperature usually ranging between 100, 101½°. For two or three weeks the man was troubled with a severe diarrhœa. A fistula in ano was discovered two weeks before his death. The last convulsions were two in succession about a month before he died. During the last weeks of his illness he did not complain much of headache. He continued to be slow in speech, but, like many phthisical patients, he rather grew in hopefulness

toward the last, and wished to leave the hospital. He was confined to bed about two weeks.

At the close of my term of service, on August 1st, the patient passed into the care of Dr. Charles K. Mills. The autopsy was made by Dr. Leys, resident physician, under the supervision of Dr. Mills.

Autopsy.—To the right of the median line, about two to three inches above the orbit, the calvarium was moderately adherent to the dura mater, and, on carefully removing the bone, it was found to be deeply eroded and infiltrated at this position over a triangular space, the greatest width of which was about two inches. The eroded area presented a caseo-purulent appearance. The inner plate of the bone had been largely worn away, and the entire bone presented a water-logged appearance. Just at this position, perforating the dura mater, was a tumor, one inch by one and a half inches in its greatest dimensions, soft and yellowish in color. It was over the anterior portion of the second frontal convolution. Subsequent examination showed the dura and pia arachnoid and cortex were loosely agglutinated. The cortex was somewhat infiltrated and softened. In a symmetrical position on the left side, an exactly similar mass was found, but it was only about one-fourth of an inch in diameter. A third similar and still smaller growth was found over the inferior parietal convolution, just behind the retro-central fissure. The ventricles were moderately dilated. The rest of the brain and spinal cord showed no gross abnormalities.

A recent pleurisy was observed over the lower lobe of the left lung, and areas of chronic pleurisy were widely distributed. In the upper lobe of the right lung was a large cavity, and both lungs showed general tubercular infiltration. No tubercular deposits were present in other organs.