HEMATOMA OF THE NEW BORN.*

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CASE 1.—T. P. was born Aug. 20, 1893, at Hospital of the Good Shepherd; weight 4½ lbs. The mother was a primipara, labor was uneventful.

History—On the second day jaundice occurred. On the same day a swelling appeared over the right parietal bone, followed soon by a similar tumor over the left parietal. Both increased in size and were limited and separated by the parietal suture until the fifth day.

Dr. John Van Duyn photographed the child and aspirated the tumors, finding blood. The jaundice deepened, the stool became green, child grew weaker, and died on the ninth day.

Autopsy.—Postmortem by Dr. Van Duyn showed infant very thin and yellow; the internal organs were normal. The tumors were beneath the pericranium and contained about six ounces of fluid clotted blood (Fig. 1).

CASE 2.—T. K. was born March 17, 1906; weight 9 lbs.

History.—The labor, in a primipara, was characterized by short pains, some delay at the inferior strait, and scanty amniotic fluid. The pelvis was large and roomy, the soft parts distensible. The cord was around the neck and there was some asphyxia neonatorum. The child's body was long and thin, and the head of the average size. On the second day a swelling appeared over the right parietal bone, and on the third day a similar swelling occurred over the occipital. Both increased in size and were separated from each other by a narrow strip at the suture, until the fifth day. The parietal tumor, which was the larger, covered the greater part of the parietal bone and rose 1½ inches or more above the surrounding level. It was ovoid, limited in the median line by the suture. The occipital tumor was circular and it seemed as if the two must coalesce. The baby was slightly yellow for two or three days, but seemed otherwise perfectly well and nursed and cried with vigor. The occipital swelling receded rapidly, the parietal more slowly.

Fig. 1.—Infant in Case 1, 5 days' old.

When the child was one month old the tumors were as they appear in Figure 2; one was nearly gone, the other was much reduced in size.

It was assumed that these tumors contained blood because of their characteristic appearance. They were smooth, tense, fluctuating, sharply outlined, limited by the sutures, unaffected by change of position and with the base as extensive as the greatest circumference, apparently painless, and occurring after birth. They are free from the scalp which they lift almost at right angles to the skull. The circumference of the base of these tumors feels like an edge of bone marking an opening in the skull beneath the tumor mass. At birth, however, if the child's head had been examined and found normal the evidence is contradictory. So, too, when the tumor gradually increasing in size changes its circumference

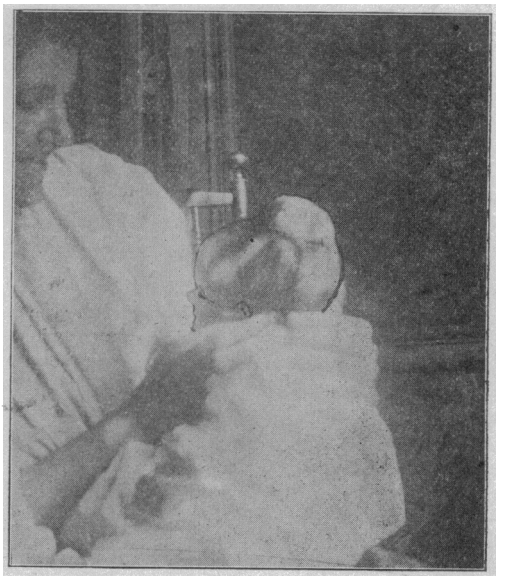

Fig. 2.—Infant in Case 2, aged 1 month.

there is a sensation of an opening in the skull, where a few hours before was palpable bone.

The cause of these tumors might be interesting if known. Theoretically, pressure during labor or by the forceps might be the cause. In practice, however, severe labors and instrumental deliveries are not as a rule followed by hematomata. No treatment except hygienic seems indicated.

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A CASE OF ISOLATED PALSY OF THE RIGHT EXTERNAL RECTUS.

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Patient.—Mrs. J. R., a house-wife, aged 25.

Family History.—Her father died at about fifty years of age of some acute illness; her mother is living and well, and is about 56 years old; two brothers and one sister are living and well. There is no hereditary taint.

Previous History.—The patient had cervical adenitis when a child, the glands broke down and opened spontaneously, and healed with considerable scarring, but quite promptly. She has had what she describes as "sick headaches" all her life. The pain is of sudden onset, is neuralgic in character, located over the left temple, left side of forehead and extending through the left eye and ear; the teeth and face are not involved. The attacks come on irregularly every two or three weeks and last from one to three days. During one of these seizures the patient is completely prostrated, is weak, dizzy and unable to hold up her head. Nausea always accompanies

an attack and vomiting frequently occurs. For two or three days after such an attack she is weak, tired and drowsy. From this time until the onset of another "spell" she is entirely free from pain and enjoys the best of health. These attacks are, of course, typical of migraine, although there is none to be found in any other of her family or relatives.

Recently she had an attack of grip, from which she believes she has recovered, although she feels a good deal "run down."

Her menstrual history is negative; the periods began at fourteen years, are of the twenty-eight-day type, moderate in amount and never very painful. She has one child nine months old, born spontaneously at term and at present quite hearty and well. There have been no abortions or premature labors. No venereal infection is acknowledged. Her bowels were always regular until her pregnancy, but have been slightly constipated since.

Present Illness.—The onset occurred while she was still feeling very poorly after the rather severe attack of influenza from which she was just recovering, and while suffering from one of her periodic headaches. The patient was walking along the street when she became aware that her vision was not so acute as usual; then she began to have difficulty in passing the people whom she met and several times collided with them and with lamp-posts and buildings. She then noticed that she was "seeing double," and came to my office greatly agitated, believing she was about to become blind. There was no other subjective complaint, except a dull frontal headache, which she believed to be of the type ordinarily troubling her; she did not associate this pain with the eye trouble.

Examination.—This showed a robust, well-nourished young woman; the skin was cool and moist; pulse, 90, soft, full and regular; temperature 98.6°, respiration, 22; she appeared to be much wrought up mentally. Speech was normal, but showed evident excitement and concern.

Subjective Symptoms: There was dull pain over both eyes, being a little worse on the left side, as is usual in her migrainous attacks. Vision was not acute, and she found that she could see very much better with the left eye alone than with the right alone, or with both eyes; also that with both eyes open, she could see much better by turning the head far to the right.

Objective Sensation: This was undisturbed (tactile, pain, temperature, stereognosis, muscle-sense.)

Gait: The gait was a little uncertain with both eyes open, and she said that she was afraid all the time of bumping against something. There was no staggering, no rigidity, spasticity or ataxia.

Reflexes: The reflexes were all normal and equal; there was no Babinski or Gordon reflex and no ankle-clonus.

Tremor: A tremor of the protruded fingers was apparent, rapid and coarse in character. (This was never present in subsequent examinations and was due to her excitement). The tongue, lips and eyelids were negative as to tremor.

Coördination: Coördination (as in touching tip of nose with extended index finger; approximating tips of fingers, etc.) was normal. She was unable to execute any very fine movements, such as threading a needle, cutting accurately with the shears, etc. The sphincters were not disturbed.

Special senses: The hearing was normally acute; taste and smell were unaffected.

Eyes: The left eye was normal in vision, field and movements. There was no ptosis and both lids followed their globes freely and normally.

The right eye showed a convergent squint entirely independent of the left eye. She could turn the right eye normally to the nasal side and was then able to abduct it through only about 30°; movements up and down were free and normal in extent. Vision was 20/60 and very easily fatigued.

The two pupils were of equal size and reacted normally to light and accommodation. There was no nystagmus; both fundi were normal. The distribution of the fifth nerve was not involved, there was no facial asymmetry.

Mentality: The mental state was normal; memory, consciousness and sleep were natural and undisturbed; there were no hallucinations or delusions.

Diagnosis.—The clinical diagnosis is, therefore, an isolated paralysis, or strictly, a paresis, of the right sixth cranial nerve, the abducens, there being no involvement of either the third or fourth nerves.

The findings already detailed will serve to locate the causative lesion. To sum up, there was a paralysis of the right external rectus muscle alone; no involvement of the other recti, the superior oblique or of the palpebral muscles, thus ruling out a lesion encroaching on the third or fourth nerve. The fundi and discs of both eyes were negative. If it were a central (cerebral) lesion, the distribution in the muscles and sensory terminals would be much more extensive. It was not located in the nucleus of the nerve affected, for in such a case the movement of the other eye to the nasal side is impaired. It was not located at the most common site of such lesions, namely at the sphenoidal fissure, for if that were the case, it would almost certainly have involved the inferior and possibly the superior division of the third, or even the fourth and the frontal and nasal branches of the fifth, all of which are in such intimate relation in this narrow passage. The lesion was, then, distal to the sphenoidal fissure and involved the sixth nerve alone—an isolated peripheral neuritis.

The pathologic process was probably a simple neuritis and peri-neuritis of rheumatic or influenzal origin, following the attack of general systemic influenza from which the patient suffered two weeks before the onset of the present trouble. Hemorrhage at this point is extremely rare, would have been much more gradual in its manifestation and, in all probability, would have involved the other related structures; there is no history of trauma and no history or evidence of arterial disease. A neoplasm would have caused very gradually increasing symptoms, among which pain would have been preeminent; the onset would have extended over months or years, and ultimately the related structures would have become involved. There is no evidence of present or past syphilitic infection; she is a total abstainer from alcoholics and temperate in all her habits.

Course of Illness.—The illness extended over nine weeks, from the onset until the recovery of normal visual and motor power in the affected eye. The improvement was steady and the recovery complete and there has been no hint of recurrence after eleven months. The general health of the patient is excellent, with the exception of an occasional paroxysm of the old pain in the head.

Treatment.—Fifteen-grain doses of potassium iodid every six hours for four days had no appreciable effect. To this was then added one-thirtieth grain of strychnia four times a day, and after ten days, when the condition was undoubtedly no longer progressive, a five to eight milliampere galvanic current was applied over the temporal and ocular regions. This was used on alternate days for fifteen minutes at a time throughout the remainder of the course of the disease. The patient experienced almost immediate benefit from this current and after the third application there was an appreciable increase in the power of abduction in the affected eye. During this same period, the fluid extract of cannabis indica was given in capsule, beginning with three minims and gradually increasing the dosage up to ten minims three times a day, for the migraine. The headaches were much improved and at the end of the treatment of the ocular palsy, the patient had been free from these prostrating attacks for six weeks. They have since recurred, in less degree, but are always promptly relieved by the cannabis indica. The patient was under my care for nine weeks, at the end of which time all movements of both eyes were normal and vision perfect, there being no pain or diplopia.

Remarks.—From a careful study of this case as here presented, I believe the diagnosis of paresis of the right external rectus oculi due to an isolated influenzal neuritis of the right abducens, peripheral to the sphenoidal fissure, is clearly justified, and is so infrequent in clinical experience and the literature as to merit such extended notice.

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