XXX.

MASTOIDITIS FOLLOWED BY CEREBRAL SYMPTOMS; RELIEVED BY DECOMPRESSION OPERATION.*

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I. A. F., male, age seven and a half years, came to my clinic at Bellevue and University Medical College on November 29, 1910, with history of having had a mastoid operation one year previously, with wound healing but persistence of aural discharge.

Two weeks before coming under my care a swelling had developed behind the ear and the lower angle of the old wound broke down. On examination, he was found to have a slight swelling over the mastoid with a sinus at the lower part, leading in a direction upward and forward, which discharged a small amount of pus. The ear was also discharging freely.

On the following day, November 30, 1910, at the New York Eye and Ear Infirmary, he was admitted to the service of Dr. Dench and the mastoid was opened. The inner table in the middle fossa appeared normal. The dura was not exposed except for a small area, where it was normal. Patient reacted well from the operation and appeared to be doing well until the second day, December 2, 1910, when at 8:30 a. m. he was taken with a convulsive seizure and became unconscious, and remained so. The movements were practically limited to left side of face and body, and were jerky in character. The eye-grounds showed enlarged veins and swelling of the discs. Urinalysis negative.

A small amount of bloody serum obtained by lumbar puncture under normal pressure gave a negative examination, except three colonies of staphylococci—probably a contamination.

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Blood count, 5,200,000 red ; 19,400 white ; polymorphonuclears, 89%. Temperature 102. As the patient had become very weak and was rapidly sinking, and evidently passing into a moribund condition, and as the convulsive movements were practically limited to the side opposite the mastoid, an exploration of the brain and decompression operation were decided upon. Thereupon, at 12:30 on Dec. 2, 1910, I proceeded to operate.

The former wound was opened and incision extended forward to about one inch posterior to the external angular process of the frontal bone, and at right angles to this and about three-quarters of an inch from anterior end another incision about one and one-half inches long, thus exposing a large area on the side of the head. The inferior surface of the temporo-sphenoidal lobe was approached by removing the inner table to very near the superior semicircular canal, the superior wall of the external auditory canal and bridge being taken down to do so. Then a large surface of the dura on external aspect of the brain was exposed, working well forwards toward motor area. The dura was then incised by crucial incision, the lower arm of which extended well on to inferior surface to near the superior semicircular canal. The brain appeared normal. Exploration with slender knife to depth of one to one and a half inches in various directions gave negative result. From inferior surface, incision of knife upward and forward for about two inches brought a free hemorrhage, easily controlled by packing the wound. Partial suture and dressing applied.

When the patient emerged from the ether he was free from convulsive movements. The dressings were soaked with serous fluid for about two weeks. Formation of moderate sized brain hernia, which, however, dermatized without difficulty, healing completely in eight weeks.