

# Society Proceedings

## CHICAGO NEUROLOGICAL SOCIETY

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The President, DR. DOUGLAS SINGER, in the Chair

### CASE OF PROBABLE ANEURYSM IN THE REGION OF THE PETROUS PORTION OF THE TEMPORAL BONE

By J. C. Beck, M.D., and H. L. Pollock, M.D.

Miss E. B., aged 21 years, consulted the speakers on the seventh of February, 1914, complaining of headaches which began about one year ago, also of lachrymation. She had had her eyes examined a month before and was told that the left eye was blind.

When two years old, she fell from a chair while standing and struck on the back of her head. Two days later began to have high fever with her head retracted. A physician said it was an inflammation of tissues covering the base of the brain. This lasted six weeks. At age of nine she was compelled to leave school for two years on account of nervousness, as she was threatened with St. Vitus' dance.

She had diphtheria when a child. About seven years ago the left ear began discharging intermittently, and then discharged for four years, but there has been no discharge for past three years. She does not hear well in left ear.

She has continuous headache, usually over left frontal region and pain down the left side of the neck. She is sometimes awakened at night by sharp lancinating pain in head, intermittent in character. She complains of dizziness when standing awhile or when stooping. Objects around her seem to be moving.

*Examination of Nose.*—Right side: Deflection of the septum high up, shutting off view to middle turbinate, corresponding concavity on left side with enlarged middle turbinate.

*Throat.*—Thickened posterior pillars and some post nasal mucus.

*Ears.*—Right ear is normal. Left ear: Large central perforation. Ear dry. Rinne positive in right ear. Negative in left.

There is a slight tremor of the tongue in the left half and that side does not seem quite as well rounded as the right side, although it does not show any great amount of atrophy.

*Vision.*—Right eye: 20/30 with plus 50 equals 20/20. Left eye: 3/100, which does not improve with lenses. Ophthalmic examination of right eye, normal. Left eye: Bleaching of lower temporal quadrant of disc. Field examination of left eye shows eccentric field, contracted on nasal side. Irregular central scotoma, with a field for red contracted to a very small central area. No perception for blue or green. Right eye: General slight contractions for all colors.

February 16. Urinalysis normal. Blood examination: Hemoglobin, 90 per cent.; small lymph., 44 per cent.; large lymph., 33 per cent.; polynuclear, 62 per cent.; eosin, 1 per cent.

February 17. Wassermann was made but proved to be negative. K. I. was prescribed in increasing doses.

March 3. Had been taking K. I. since February 17 and now taking 20 grains three times daily, but she is very nauseated and has an iodine rash.

March 4. A spinal puncture was made, the fluid escaping under moderate pressure. Examination of the fluid showed Wassermann, Nonne-Apelt, Lange all negative, but there were 50 cells to a cubic millimeter. Advised to remain under observation.

March 10. Since the puncture was made, patient complained of having a pressure in head, seeming to radiate into both temples, especially when in the upright position. Relieved when she reclines.

March 12. X-ray stereo-radiograms were made of head and neck and were found to be negative as to any findings.

April 15. Condition the same, although headaches somewhat better, and patient feels stronger.

May 19. Returns complaining of frontal headaches. Fundus examination shows left nerve-head white. Vessels more tortuous, vision gone completely, no light perception. During the summer patient went to the country and reports state that she was feeling fine and gaining in strength.

July 14. She was referred to Dr. George Hall for examination. His diagnosis was that there was probably a gliomatous process involving the basal ganglia.

September 14. Feeling fine. Just returned from the country. Atrophy of left side of tongue more perceptible, also more tremor. Soft palate and uvula draw slightly to right. Showing a slight paresis of left side. Both arytenoids movable. Can not see cords. Left pupil reacts to accommodation, sluggish to light. Fundus shows no change.

September 29. Patient returns, showing a paresis of the external rectus and a slight edema of both eyelids with a beginning exophthalmus.

October 26. Condition the same except more headache and considerable exophthalmus.

A decompression operation was advised.

*Operation.*—October 30. General anesthetic. On account of the old middle ear suppuration, the mastoid was opened and was found to be normal. The dura was exposed in the region of the attic and was also normal. Going backward from the upper mastoid wound an area of bone about  $3 \times 2\frac{1}{2}$  inches was removed, thus exposing the supra- and infratentorial region. The dura appeared normal and no bulging or tension discovered. The dura was split and the underlying brain tissue appeared to be normal. While exploring with the index finger over the posterior surface of the petrous portion of the temporal bone a sudden gush of venous blood occurred. This bleeding was tremendous and the region was immediately tightly packed with gauze, but notwithstanding that the lateral sinus was clamped off both anteriorly and posteriorly to this region, the bleeding continued and not until the internal jugular was ligated did the bleeding become less. At this time the patient was pulseless and almost gone. The gauze was left in situ, the dura stitched and the external wound closed hurriedly, except at the postinferior angle of the wound, where the gauze was left for drain. The patient was stimulated and

quickly responded and in a few minutes was conscious and speaking. The gauze was left in for a week, gradually being withdrawn.

The patient had never any rise in temperature, nor any more bleeding. She made an uneventful recovery. She now states that she feels better than she has for years, feels stronger and has no headaches. The exophthalmus and paresis of the sixth are gradually improving. She has now light perception in the temporal side of the eye. The paresis of the tongue and soft palate are about the same.

Dr. Hall said that, according to his record, the heart was negative. His findings, independent of those of Dr. Pollock, in July, showed that the patient complained of headache, extending down the back of the neck, in the left occipital region. The blindness in the left eye began February, 1914. The right eye was normal. There was no history of vomiting. Examination showed the right pupil normal; left one, no reaction. Tongue atrophied on left side—deviated toward the left. Soft palate showed paresis on left side. The patient stated at that time that she lost her voice at times, but not for any length of time. She had a peculiar speech, more or less characteristic of a bulbar condition. Slight nystagmus to the right. Seventh nerve on left side showed slight paresis. Fifth nerve showed no apparent involvement. Drooping of left eyelid at times. Sixth nerve showed paresis. Left eye more prominent than right. The eighth nerve apparently affected; complete deafness in left ear. No other evidence of paralysis or sensory disturbance, according to the speaker's findings in July, and no evidence of cross-paralysis, which he looked for very carefully at the time. Since operation the patient states that the headache is much less than it was, but on examination, December 11, the speaker noticed, on looking at the left eye, that she seemed to be able to detect light on the nasal but not on the temporal side. Right eye normal at that time, reacting to light. Pupil of left eye at that time slightly smaller than right. Palpebral fissure rather narrow on left side. At that time the patient complained of slight headache.

The diagnosis made by Dr. Hall in July was a brain tumor—very likely a gliomatous growth in that region. The thought of aneurysm did not enter the speaker's mind, because the test for syphilis was absolutely negative and she had no heart lesion. The speaker would hardly be willing to make a diagnosis of aneurysm unless he had very positive findings to substantiate such diagnosis. Even after seeing the patient again he would not be willing to make the diagnosis of aneurysm, rather than tumor.

It was easily seen, with the decompression operation made, that the temporary results might be present in case of tumor, and it seemed to the speaker a little too soon to make the diagnosis of aneurysm. Time alone would tell whether or not there will be recurrence of the symptoms.

Dr. Peter Bassoe thought it doubtful that there was an aneurysm present in the case exhibited. In cases of aneurysm there is apt to be a bruit, which is absent in this case.

In regard to the gush of blood at the time of operation, referred to by Dr. Pollock as being from an aneurysm, it would seem to the speaker very unlikely. If there was an aneurysm large enough to cause loss of vision in the left eye and affect all the nerves down to the hypoglossal, such hemorrhage at the time of operation would not be stopped by simple ligation of the jugular vein.

Dr. Pollock (closing) said that he had nothing further to say, except

that the diagnosis had been one of "probable aneurysm." It was not positively diagnosed as an aneurysm, but such condition was thought probable. The condition was one embodying a large circle of veins. It was a venous bleeding that occurred at the time of operation, not arterial. It had been intended to explore the pontine cerebellar angle, but it was impossible to continue with the operation, owing to the condition of the patient. Finding nothing else but this tremendous gush of blood from the veins, they concluded that it was a case of involvement of a large number of large veins, sort of a bloody tumor which was ruptured.

One other thing, namely, the fact that there was a depression instead of a hernia present. Pulsation is present. So far, the symptoms have improved; the vision is better. No headaches; patient feels better than she has for years. There is no improvement in the paresis of the tongue or soft palate.

### CASE OF ACROCEPHALOSYNDACTYLISM

By Benjamin F. Davis, M.D.

The patient was a girl, three years of age. She was born at term, normal delivery, no hydramnios. The family history is negative so far as deformities similar to this are concerned. The patient is the youngest of four children. Between the second and third children the mother had two miscarriages. The Wassermann test of the patient's serum is negative.

The features characteristic of this clinical entity are found in the peculiar deformity of the skull, the syndactylism of the four extremities and the malformation of the hard palate. The skull is flattened posteriorly in such a manner that the external occipital protuberance is lacking. The squamous portion of the occipital bone is smooth and vertical. Just above the lambdoid suture the skull bends forward and upward; the highest portion is at the bregma and runs over quite abruptly into the plane of the forehead and face. Although the frontal area has in general a vertical direction, there is a bulging in the middle portion which is separated from the superciliary ridges by a shallow furrow. The frontal suture is open for its entire length of nine centimeters; its greatest width is four centimeters. The orbits are highly arched; the superciliary ridges are much flattened, and the roofs of the orbits are tilted downward and backward at about an angle of forty-five degrees from the normal, so that they are easily palpated. There is marked exophthalmos. In the eye-grounds, examined by Dr. Darling, there is some tortuosity of the retinal vessels and slight evidences of edema of the nerve head. The temporal and zygomatic regions bulge markedly, making the face somewhat the shape of a kite. The bridge of the nose is depressed. There are ten strong though rather poorly formed teeth on each jaw. The right and left alveolar ridges of the upper jaw project medially, coming into direct contact in their anterior portions, thus forming a sort of balcony above which is the highly arched hard palate.

The mentality appears to be fairly normal for a child of this age, although it is difficult to form a judgment on that score.

The hands were operated upon by Dr. Carl Beck three times during the first year of the patient's life. Preceding the operation the characteristic type of syndactylism was present. The union was more intimate