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CEREBELLAR ABSCESS.*

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Cases of cerebellar abscess, while not very uncommon, are always of interest to the otologist, and I therefore take the liberty of reporting this case, treated by me on the service of Dr. Dench, at the New York Eye and Ear Infirmary.

R. A., male, aged thirteen years, came into the hospital on July 1, 1912, complaining of trouble in left ear, with history of attacks of pain in the ear for past six months, associated with a slight discharge which had some odor. Two weeks previously he began to have headaches and pain in the neck and, later, in the arms and legs. He vomited, several times daily, after taking food, was dizzy, and walked with difficulty. The drum membrane was bulging. This was incised, giving some relief.

On admission the facial expression was somewhat dull; slight mental dullness; no aphasia. Pupils equal; react to light; fairly dilated. Frontal headache. Temperature 102.4°. Right ear normal. The posterior wall of the left ear was thickened and red. There was pus over membrana tympani, which was bulging. Myringotomy was performed, accompanied by free hemorrhage.

Physical examination showed lungs normal and evidence of cardiac involvement—probably mitral stenosis. An examination of the aural discharge showed a mixed infection, with pneumococcus predominating. White blood cells, 18,000; polymorphonuclears, 62.8 per cent. Blood culture negative.

Radical operation was done on the following day, July

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3d. Cortex was hard. There was considerable involvement of the mastoid cells. The antrum and middle ear was filled with cholesteatomatous material. Following this operation the patient appeared much better. His temperature became lower, remaining between 100° and 101° , except for one sharp rise to 105° , which was accounted for by an acute tonsillitis.

On July 7th he complained of headache. Examination of the eyes showed changes in the eye grounds of both sides; slight ptosis in left upper lid.

July 8th, leucocytes, 16,400; polynuclears, 81 per cent.

July 10th, patient still drowsy. No nystagmus. Kernig's sign absent; reflexes normal. Lumbar puncture, 20 cc., was withdrawn under moderate pressure. Widal reaction was negative.

July 11th, more drowsy. Lumbar puncture, 20 cc., was withdrawn under increased pressure. Kernig mildly present. Positive Babinski—more on left side. As there was evidently some intracranial complication, an exploration was determined upon. Accordingly, the dura in the middle fossæ was exposed, both over the floor and externally, in the region of the squama. It appeared normal. A small elliptical incision was made through the dura, and a grooved director, passed in various directions, gave negative results, except when passed directly inward for about one and one-quarter inches. Then there was a gush of cerebrospinal fluid, evidently under great pressure, and in amount about four ounces. As the patient was in poor condition, the pulse being weak and in the neighborhood of 160, further interference was postponed. It was hoped that the evacuation of this fluid might produce some amelioration of the patient's condition. On the following day, July 13th, the condition was not improved. Leucocytes, 27,000; polymorphonuclears, 90 per cent. Blood culture negative. Temperature 103° . The dura was exposed over an area of about two inches in diameter, over the cerebellum, working back from the mastoid wound. At a point one inch posterior to the sinus, a small dural incision was made and pus was evacuated at a depth of about one-eighth of an inch. Nearly a teaspoonful of pus

was thus obtained. A cigarette drain was inserted and the wound was packed.

On the following day (14th) the patient seemed clearer and somewhat better. Temperature 102°. At 3 p. m. the wound was redressed and a gauze drain inserted. At 6 p. m. the patient ceased to breathe, although the pulse beat continued, and, notwithstanding artificial respiration and other measures, the patient died at 6:30 p. m. No autopsy was obtained.

This patient never had subnormal temperature or pulse. There was absence of nystagmus. The caloric reaction was present. The infection probably traveled from the mastoid internal to sinus.

The presence of ventricular distension as a result of cerebellar abscess is well shown in this case. This point is brought out and emphasized by Dr. Dench in his book on "Diseases of the Ear."