

Macroscopically the tumor consists of an encysted colloid growth, situated in the third ventricle and probably originating from the ependyma. It is attached to the inferior surface of the center of the fornix and velum interpositum. It is ovoid in shape, thickest at the center, where it is about 2 cm. in diameter, and rapidly decreasing in size anteriorly and posteriorly to small pealike extremities. The growth originates posteriorly to the anterior commissure, occluding the foramen of Monro on the right side and dilating it also. By virtue of the direction of its growth from left anterior to right posterior, the tumor enters the lateral ventricle of the left side through the foramen of Monro (which it occludes). The ventricular portion of growth is about the size of a pea, greenish, mottled with yellow. The tumor by the growth drags the septum lucidum and fornix to the right and compresses the right optic thalamus more than the left. Below it lies on and separates the corpora albicantia and rests on the infundibulum. The anterior extremity of the growth, which projects into the lateral ventricle, passes above the anterior commissure. The tumor extends backward to a point just anterior to the middle commissure, where it ends in a small pealike growth. A plica in the septum lucidum curved to the right persists throughout. The tumor does not press on the red nucleus or occlude the entrance to the third ventricle posteriorly to the middle commissure.

The pineal gland is not encroached on. The aqueduct is small and the third ventricle above the middle commissure is dilated. The tumor is dark green except at the anterior portion, where it is mixed with yellow. The capsule surrounds it entirely and it is easily shelled out except at the upper and lateral right borders where it tears, showing a colloid, cheesy appearance, spotted with what appears to be degenerated blood pigment. The capsule is attached on both sides to the walls of the lateral ventricles, and the choroid plexus is seen to enter the third ventricle beneath the capsule of the tumor and forms a very slight elevation. The lateral ventricles are dilated, the right more than the left, and the choroid plexus on both sides show the formation of small cysts.

Microscopically the tumor consists of an encapsulated colloid cyst originating from a glioma. At the portion firmly attached to the cyst wall, the greatest number of undegenerated cells and nuclei are found. The capsule at this point is thickened, the connective tissue forming layers, between which are seen numerous lymphocytes, glia nuclei and a few Abraumzellen. The optic thalamus beneath this portion of the capsule is seen to contain a few Abraumzellen and a greater number of nuclei. The tumor proper consists of a greenish homogeneous material, embedded in which are numerous Abraumzellen, staining red with scarlet r. containing many globules, showing black with Bielschowsky stain. Within the Abraumzellen are found nuclei showing fatty degeneration, red blood cells and debris, fatty granules, and at the periphery of the cells, frequently a crescentic flattened nucleus. There are likewise seen throughout the tumor many colloid bodies, nuclei, lymphocytes and red blood cells. There are no fibers found within the tumor mass.

It is interesting to note that of thirty cases of third ventricle tumor collected by Weisenburg, only three extended into the lateral ventricles at all, and these protruded only slightly through the foramen of Monro, as was the case with the tumor here recorded. The tendency for growth is in the direction of the flow of cerebrospinal fluid. It is apparent that this tumor, which occluded the foramen of Monro, whose position did not change with deviation of the head, which did not extend into the aqueduct of Sylvius, and which but slightly compressed the pons, would, according to Weisenburg's classification, be placed in the third group. It would seem possible that, had not this tumor attained such a large size, it would have occupied the same position without resulting pressure on the pons, and, in such case, should properly be placed in a

separate group in which the tumor is so situated that it occludes the foramen of Monro whether its position changes with variation in the position of the head or not. The cases in which these tumors are changeable in position should then be classified in a subgroup under this head. The symptoms of the group would be dependent on, first, the degree of hydrocephalus and, second, the amount of pressure on the surrounding structures. Inasmuch as there have been four colloid growths reported which did not extend into the aqueduct of Sylvius, and three other cases, excluding this tumor, which extended into the lateral ventricles through the foramen of Monro instead of the aqueduct of Sylvius, it is highly probable that this group will assume greater importance with the subsequent report of cases.

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THE LESION IN A CASE OF SEROUS COLITIS

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Between the purely functional diarrheas, on the one hand, in which we believe no anatomic changes are associated with the disturbed activities of the bowel, and the well-defined dysenteries, such as croupous and amebic colitis, on the other, in which evident and often extensive lesions are always present, there lies a large intermediate group of cases, in which it is by no means easy to be sure whether actual anatomic lesions exist or not. The main reasons for our ignorance in this matter are first: such conditions are not, of themselves, fatal in adults so that postmortem examinations are rare; and second, if the changes are only those of congestion and exudation, they may easily be impossible of demonstration after death.

To the group in question, the general term "catarrhal colitis" is applied, and it may be subdivided as follows:

1. Catarrhal colitis in children which may become so severe as to take life, and regularly shows a swelling and sometimes a rupture of the solitary lymph follicles.

2. Catarrhal colitis in adults, with mucus the chief inflammatory product.

The lesion in these cases has been described by Delafield.¹ The lower end of the large bowel is the most frequently inflamed. The pathologic changes are congestion of the vessels of the submucosa and mucosa, with an abnormal quantity of mucus in the cells lining the tubulæ. There may be some emigration of leukocytes and some diapedesis of red cells. No ulcers occur, and the solitary lymph follicles remain unchanged. There are very frequent small passages composed of a few drams of mucus, in acute cases often blood streaked. Fecal matter is absent at first, and when it appears is usually formed, though very variable in amount. Colic and tenesmus accompany the movements. There is usually some fever.

As an example of this type I find the following among my records:

CASE 1.—Man, aged 25, began at 3 a. m. to have repeated small movements of bloody mucus associated with colic and rectal tenesmus. A passage which I saw was composed of about 3 drams of bright bloody mucus and nothing else. The

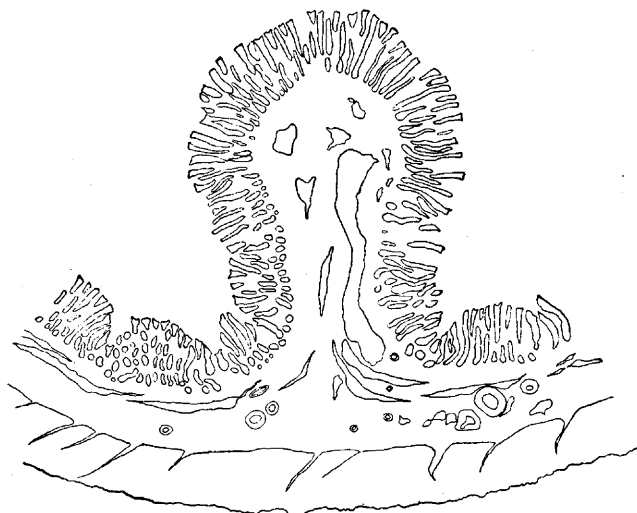
1. Delafield: *Am. Jour. Med. Sc.*, N. S., 1897, cxiv, 401.

patient had little prostration and no fever and got well in two days with rectal irrigations.

3. Catarrhal colitis in adults with serous fluid the chief inflammatory product.

This condition differs clinically from the foregoing.

The passages are copious, from one-fourth to one pint, at first soft fecal, then simply gushes of watery fluid, either green or brown, often preceded by colic



Camera lucida sketch of section of colon, showing outlines of the larger lymph channels in submucosa; $\times 15$.

but unassociated with tenesmus. Blood does not occur, and mucus is absent or nearly so. The patients are prostrated and may even faint after a large passage. There is little or no fever. The condition lasts longer than the mucoïd form, and if untreated, may run for weeks.

The following case, also from my private records, serves to illustrate the condition.

CASE 2.—Man, aged 35, without known cause, was taken with abdominal cramps and chilly sensations followed by fourteen large watery movements in twenty-four hours. The passages contained a few flakes of fecal matter but no mucus or blood. He did not suffer with tenesmus. He vomited once, was nauseated and much prostrated. With rest in bed and appropriate drugs the symptoms promptly subsided.

The lesion of this form of colitis has, I believe, not been described. I wish, therefore, to report the following case from the second medical division of Bellevue Hospital:

CASE 3.—A laborer, aged 41, was sick and died of a lobar pneumonia on the eighth day. On the sixth day of his illness, following a dose of salts, he began to have frequent copious watery discharges, without pain or tenesmus, which continued to the time of his death. In the two days he had about twenty passages of brown or green fluid, containing no fecal matter, no blood, and practically no mucus. He did not vomit. At necropsy, three hours after death, the heart was found normal. The whole right lung was consolidated. The stomach was distended with gas and a quart of light green, turbid, serous fluid, and its wall was coated with thick, tenacious mucus but not at all congested. The small intestine contained a moderate amount of viscid yellow chyle throughout. There was moderate gaseous distention of the jejunum; it was normal. The colon contained a little gas and was nowhere tightly contracted, though rather smaller than usually seen at necropsy. It was empty through its entire length, containing altogether about a half ounce of soft mucoïd fecal matter, mostly in the caput. The mucosa was

strikingly clean and edematous, looking as if it had just been washed in running water. There were no congestion, no ulcers, no hypertrophied lymph follicles. Under the microscope the mucosa and muscle coat were normal. The submucosa, only, was markedly thickened by edema, and its lymph spaces truly enormous. The accompanying illustration shows the relative dimensions of the larger ones. There were no congestion, no diapedesis of red or white cells and no follicular hypertrophy. There was marked thickening of the walls of the larger vessels, not due to muscular or connective tissue hypertrophy, but to a homogeneous swelling of their elements.

It is, of course, uncertain, with the bowel symptoms only an incident in the course of a lobar pneumonia and beginning after a saline, whether the lesion is characteristic of serous colitis or not. But necropsies are so rare and the pathologic features of the colon so definite and peculiar and yet so intelligibly associated with a copious serous exudate, that I have thought it proper to put the case on record as a contribution to the pathology of the condition.

A FENCE STAPLE IN THE LUNG

A NEW METHOD OF BRONCHOSCOPIC REMOVAL

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The mechanical problem of the bronchoscopic extraction of an open safety-pin lodged point upward in the trachea or the bronchi is readily solved because of the ease with which the pin can be closed or cut in two for removal. With the double-pointed staple, however, we have to deal with a rigid body of tough steel that cannot be bent, sprung or broken. The author has succeeded in three cases in turning and withdrawing the staple by a method which is best illustrated by the last and most difficult case.¹

Mr. W., aged 44, was referred to me by Dr. L. P. Warren of Wichita for the removal of a fence-wire staple which

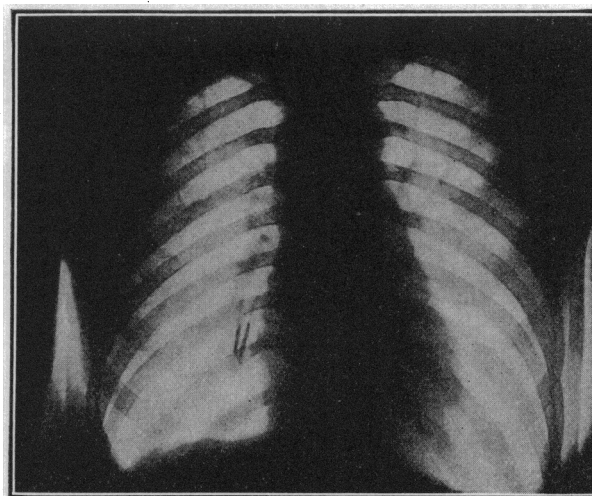


Fig. 1.—Anteroposterior view of chest showing staple in a posterior branch of the inferior-lobe bronchus. (From roentgenogram by Dr. George W. Grier.)

had been in the right lung for fifteen days, having been aspirated while being held in the mouth. There were no symptoms after the accident. Roentgenograms made for me by Dr. George W. Grier showed the staple to be in the lower lobe of the right lung (Figs. 1 and 2). Overlaying with my positive films of the tracheobronchial tree showed the

1. Since the foregoing was written, a fourth case has been similarly successfully dealt with. The points of a very large staple were turned down into the opposite main bronchus.