Connors (50)

[redacted]s: Pvt. [redacted] AB Inf. BC.

Onset: March 1943 - of suboccipital headache.

Admitted: 27 Sept. 1943 - source ?

Died: 8 Oct. 1943 - of purulent meningitis, source undetermined.

This 19 year old soldier first complained of suboccipital headache 8 months ago, worse on right and progressively severe, at times vomiting without warning, or after eating with sudden turn of head or quick motion. Dizzy but never fallen. Diplopia and triplopia past month. Never unconscious or had fits. No history of exertion. Keeps left eye closed to avoid diplopia and closes right only when left is closed. Reels from side to side on walking and with eyes closed totters to right. No aphasia or astereognosis. Finger to nose OK. Difficulty in stopping suddenly. Tendon reflexes OK. NO Babinski. No sensory loss or paraesthesia and no sense or smell disturbance. Tapping on skull at base of neck to right of nuchal line is painful. Eyes react promptly but incompletely to light and accommodation. Papilledema of 4 to 5 diopters, vessels are engorged. Fields OK and no nystagmus. Right facial weakness. Questionable left deviation of tongue. Ordinary Xray negative, blood and spinal fluid negative, ventriculogram was unsatisfactory. With diagnosis of space occupying lesion in cerebellum a suboccipital craniotomy was done 5 Oct., with no findings. On 7 Oct., the patient had sudden shaking chill and temperature rose to 106. He died in a few hours.

Autopsy: 5,7.

A. The brain is removed in the normal manner and shows striking change. Over the parietal convolutions, but more marked on the right, is a diffuse subarachnoid collection of gray-yellow exudate. Similar changes, but more pronounced, are found about the base, particularly in the posterior fossa. Both cerebellar lobes are diffusely hemorrhagic and injected. The entire brain is unusually soft and edematous. Immediate section demonstrates that the exudate is limited to the subarachnoid spaces. The ventricles are normal and free from obstruction. Nowhere, even on ½cm section, can an abscess pocket be discovered. The pons and cerebellar structures were particularly scrutinized, but no inflammatory focus was found. Both middle and inner ears apear dry and unchanged. There are no changes in the various bony sinuses. The cervical cord is entirely normal. The sphenoid sinus is unusually large, and the posterior clinoids abnormally small, but these changes are obviously congenital and not due to erosion through disease.

B. Although this patient's pre-operative clinical picture was that of a space-occupying lesion in the cerebello-pontine angle on the right side - and hence presumably an acoustic neurinoma - none was found at operation or in the autopsy which followed. Yet the patient quite obviously had a focal lesion. From the occurence of a septic meningitis (hemolytic strptococci were recovered in postmortem cultures of the brain), one might postulate the existence of a silent abscess of the pons.

C. While no focal abscess was found here, I am confident that there must have been some focal inflammatory lesion which was responsible ## for the original clinical picture.

Diagnoses:

CLINICAL DIAGNOSES

(1) Right cerebello-pontine angle tumor.

PATHOLOGIC DIAGNOSES

(1) CARDIOVASCULAR SYSTEM: None
(2) RESPIRATORY SYSTEM: Acute diffuse hyperemia and edema of both lungs.
(3) SPLEEN & HEMATOPOIETIC TISSUES: None
(4) GASTROINTESTINAL SYSTEM: None
(5) LIVER: Hepatitis, acute, diffuse, (septicemic).
(6) PANCREAS: Fatty infiltration, minimal.
(7) GENITOURINARY SYSTEM: Acute passive hyperemia of both kidneys.
(8) CENTRAL NERVOUS SYSTEM: Acute diffuse purulent meningitis, recent, due to hemolytic streptoccocci from portal unknown.
(9) ENDOCRINE GLANDS: None
(10) BONES & JOINTS: Recent bilateral suboccipital craniotomy (crossbow incision)
(11) MISCELLANEOUS: Obesity, moderate; hyperthermia; cyanosis of nail beds.