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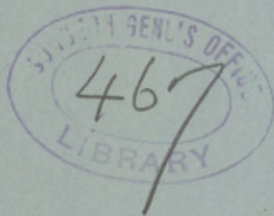
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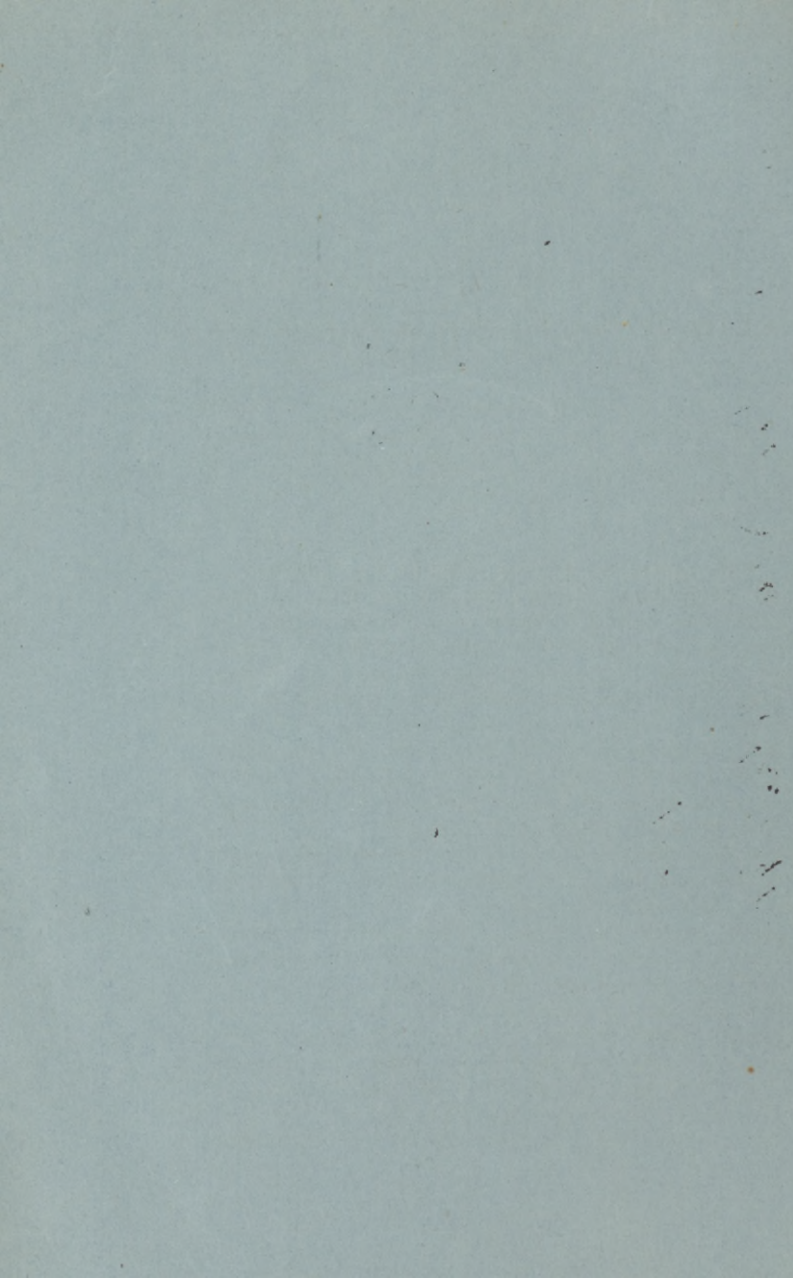
JAMES HENDRIE LLOYD, M.D.,

PHYSICIAN TO THE NERVOUS AND INSANE DEPARTMENT OF THE PHILADELPHIA HOSPITAL, TO THE METHODIST EPISCOPAL HOSPITAL,
AND TO THE HOME FOR CRIPPLED CHILDREN.



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**A CASE OF TUMOR OF THE MID-BRAIN AND
LEFT OPTIC THALAMUS.**

BY JAMES HENDRIE LLOYD, M.D.,

PHYSICIAN TO THE NERVOUS AND INSANE DEPARTMENT OF THE PHILADELPHIA HOSPITAL. TO THE METHODIST EPISCOPAL HOSPITAL,
AND TO THE HOME FOR CRIPPLED CHILDREN.

THE patient whose case I report was admitted to the Philadelphia Hospital on May 13, 1891. A very brief and imperfect history was obtained from his sister. They were Italians, with very little knowledge of English. C. B., male, aged twenty-eight, Italian laborer, was taken ill six weeks before admission to the hospital. His first symptom was paralysis of the right arm; fifteen days later he complained of severe headache on the left side; at the same time his left eyelid began to droop. No other details of any importance could be obtained from the sister.

Condition on admission. The patient's attention could be attracted, but was held with difficulty. This hebetude continued throughout the case, toward the end deepening into a light coma. The left third nerve was paralyzed, as shown by ptosis and external strabismus. The pupil was immobile, but at this time not dilated. The right arm was completely paralyzed; the right leg was paretic, but not completely paralyzed, as the patient, by repeated urging, could be induced to move it. The left arm and leg were not paralyzed and never became so. The patella-reflex of the left leg, however, was exaggerated and there was slight ankle-clonus. Neither of these

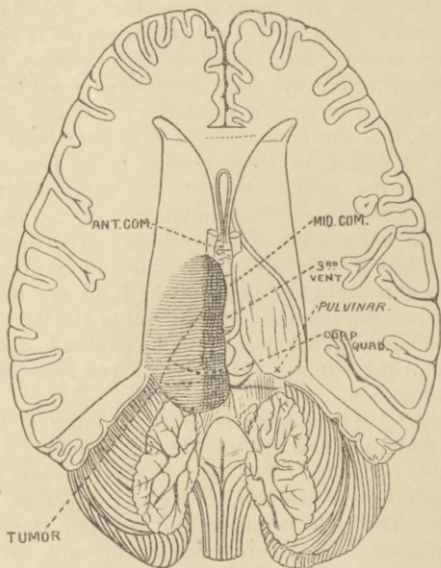


were present on the right or paralyzed side. The case thus presented a crossed paralysis, the left third nerve being involved, with right brachial monoplegia and right crural monoparesis. The face and tongue were not paralyzed on either side—in fact, from beginning to end no paralysis of the fourth, motor branch of the fifth, the sixth, the seventh, or any other cranial nerve than the third was observed. The patient chewed his food mechanically and swallowed without difficulty.

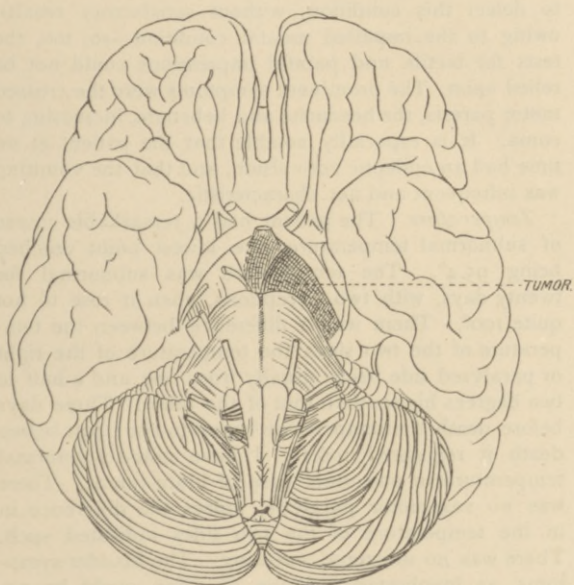
An Italian interpreter on one occasion said that the patient's speech was not "straight," but this defect was apparently not a true aphasia. The patient vomited occasionally, but vomiting was never a marked symptom. The bladder was not paralyzed. The sensory tests were not at any time satisfactory, owing to the patient's hebetude. Some interesting observations of a rather unusual kind, however, were made. There was no apparent anesthesia of either side, so far as the patient's mental condition allowed of a test. There was, however, an active reflex to sensory irritation. This reflex was free on the left side and was excited by irritation of the skin of the right leg; in other words, there was a transmitted reflex on the left or unparalyzed side from sensory irritation of the right side. Irritation over either the right or the left eye caused a reflex movement in the left or unparalyzed leg. The reflex to painful impressions was more marked in the upper part of the face than in the lower part of the face and showed itself by jerks of the arm and leg. The patient's hebetude gradually increased; he complained of pain in his head, and held his hand to his head as if in pain. Occasional vomiting was noted. He was very restless and delirious at night. Examination of the urine showed a very slight trace of albumin. At the end of the first week the patient had some difficulty in swallowing; his right leg became more paretic, and he could be aroused with difficulty. This general condition,

continued, with increasing hebetude, occasional vomiting and constipation of the bowels. The paralysis of the third nerve and of the right arm and leg continued unaltered. The left pupil became more dilated. The right third nerve never became involved, which, considering the site of the tumor, is rather remarkable. Later, the right face became possibly a little flattened. Three weeks after admission conjunctivitis in the right eye was noticed, with increased lachrymation, but the movements of the eye were unimpaired. Sensory tests of the right eye were not satisfactory. It was thought, however, that the conjunctivitis may have been neuro-paralytic in origin, as there seemed to be loss of sensation of the conjunctiva of this eye. There was also an abrasion of the conjunctiva of the right eye over the lower part of the cornea. The eyes were washed with a solution of boric acid and eserine. Two days before death the pupil of the right eye was contracted to a pin-point, while the pupil of the left eye was much dilated. Just before death the patient had a clonic spasm of the left leg. He died on the twentieth day after admission.

Autopsy. The autopsy revealed a tumor of the left optic thalamus and the mid-brain, involving the left cerebral peduncle. The left cerebral peduncle was enlarged and the left third nerve was displaced by the growth. The right peduncle and the right third nerve were normal. The tumor extended forward, involving and obliterating the corpora mammillaria. The optic tract was slightly flattened and broadened. On laying open the brain-axis, by carefully removing the corpus callosum and the arch of the fornix, the tumor was seen to extend forward and to involve a large part of the left optic thalamus, which projected far across the third ventricle; it also projected up into the lateral ventricle. The aqueduct of Sylvius was pervious. On section, the growth was seen to be a soft, highly vascular, infiltrating



Tumor, involving left optic thalamus and left half of mid-brain.
(Seen from above.)



Tumor, involving left crus and extending forward and inward,
involving and effacing corpora mammillaria.

tumor. A section was prepared by Dr. Stengel, and the growth was found to be a glioma.

It seems impossible for this tumor not to have involved the sensory tracts to a greater extent than was demonstrable at the bedside. For instance, the patient probably had had hemianopsia. Careful tests were made to detect this condition, without satisfactory results, owing to the impaired mental condition—so, too, the tests for tactile and painful impressions could not be relied upon. The prominent symptoms were the crossed motor paresis, the headache and hebetude, increasing to coma. It is especially notable that the patient at no time had an epileptic convulsion, and that the vomiting was infrequent and not characteristic.

Temperature. The patient had a remarkable course of subnormal temperature, the lowest point reached being 95.4° . The temperature was subnormal for twenty days, with two exceptions, when it rose to not quite 100° . There was a difference between the temperature of the two sides, the temperature of the right or paralyzed side being usually from one and a half to two degrees higher than that of the other. Three days before death the temperature began to rise; just before death it registered 106.1° . I have noted subnormal temperature in one other case of brain-tumor. There was no vasomotor paralysis, unless the difference in the temperature of the two sides indicated such. There was no unilateral sweating. The bladder-symptoms, as involuntary passage of urine, could be explained by the patient's mental condition.

A diagnosis of tumor of the left cerebral peduncle was made at the first examination.

I am indebted to Dr. Frances S. Janney, resident physician, for careful notes of the case.

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