CASE 6

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(VAH Augusta, Ga., #10961) M.G., a 60 year old white, married male was admitted to the hospital on 1 October 1944 and died in the same institution on 30 September 1960.

According to the wife, the patient's illness began in 1929 as manifested by increasing personality changes. By 1944 these changes had become so severe that on one occasion he was picked up by the police and admitted to a hospital. He exhibited a definite behavior of grandeur. Neurological examination (1944) revealed a small contracted pupil which reacted only slightly to light. The clinical diagnosis was Paresis. Most of the laboratory examinations performed were within normal limits including the blood Wasserman reaction. The spinal fluid examination revealed a 4 plus Wasserman reaction and a colloidal gold curve of 4444210000. A review of the past history indicated that the patient had served in the Armed Forces during and after World War I. He apparently contracted syphilis overseas and, in 1920, was treated; details concerning the disease and the subsequent treatment were not known. The familial history was not contributory.

The patient was now treated with malaria followed by chemo-therapy. Mentally the patient did not improve but deteriorated. He cooperated poorly and soiled himself frequently. In 1948 his gait became unsteady and by 1951 he was mentally completely out of contact. At this time, a diagnosis of hypertensive cardiovascular disease was also made. Annual physical examinations for many years subsequent to 1951 were reported as showing no appreciable change. In 1958 inguinal herniorraphy was performed.

About 5 weeks before his death the patient was noted to have a cold. Twenty-six days before his death the patient felt very weak and he fell while on his way to the hospital chapel. Following the accident he perspired profusely and indicated to have pain in his left arm and shoulder. Subsequently, he was noted to stumble while walking and, 22 days before death, a considerable increasing difficulty swallowing, which necessitated liquid feedings. Eighteen days before his death an x-ray examination of the chest revealed a mass in the left hilar region suggestive of carcinoma. In addition there was a large calcified node in the midportion of the right lung previously diagnosed as "calcified tuberculosis." Nine days before death the weakness in the right foot was more pronounced and this together with the difficulty of swallowing was suspected to represent the signs of a stroke. The deep tendon reflexes on the right side appeared increased and a questionable right Babinski sign was elicited. During the last day of life the patient became less responsive and finally exhibited signs of peripheral vascular collapse and severe pulmonary edema.

The essential gross finding in this autopsy (FA 60-91) was a bronchogenic carcinoma, approximately 4 cm. in diameter, involving the upper lobe bronchus and the main bronchus of the left lung, and metastases to the liver.

The brain which externally was not remarkable, weighed 1400 gms. The cerebral arteries contained little atherosclerosis; the circle of Willis was symmetrical. During the course of dissection a small, white-gray, granular tumor measuring 2x1 cm. in largest dimensions was noted in the midline in the region of the pineal gland. This was the only tumor in the brain. A slight dilatation of the third and lateral ventricles was noted.