CASE 8

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Ref. No. A60-489

This 42 year old man was first admitted to Henry Ford Hospital on July 10, 1960 with a history of two months easy fatigability, weakness and some weight loss, and a leucocytosis of 24,100. In addition, he had had a low grade fever and had been shown to have impairment of his liver function studies.

On examination, the patient was lethargic, had a short attention span, a left homonymous hemianopsia, a left facial weakness, and a left hemiparesis. He had left-sided extinction with amorphagnosia, astereognosia and constructional apraxia, and dressing apraxia on the left. The fundi were negative and showed no evidence of papilledema. The heart and lung examination, as well as the remainder of the general physical, was within normal limits.

On July 18, 1960 a right percutaneous carotid arteriogram was done which showed a shoft of the right anterior cerebral artery to left with the right middle cerebral artery elevated and slightly displaced medially. The same day the patient was taken to the Operating Room where a right frontal temporal craniotomy was performed with removal of 115 gms. of a hard, firm neoplasm which grossly resembled a "meningioma." Following this, the patient had some spontaneous drainage of purulent material from beneath the scalp flap which required re-elevation of the flap on August 2, 1960. The patient was then discharged on August 7, 1960, and readmitted on August 22, 1960 because of his developing right-sided headaches, again drainage from the flap and increasing weakness of his left side with pain in the right eye.

At this time, the patient was alert but slow mentally. He was well oriented. He demonstrated a left facial weakness. There was no papilledema. The reflexes were increased on the left side. There was an extensor plantar response on the left. There was almost total disregard for the left extremities and the patient still had a complete left homonymous hemianopsia.

On August 23, 1960 a repeat right carotid arteriogram showed even more shift of the right middle cerebral than before. A right frontoparieto-temporal craniectomy was done and removal of 70 gms. of neoplasm was carried out.

On August 30, 1960, 42 gms. of tumor were removed from the right temporal region. Following this the patient's course was one of gradual deterioration with an increasing bulging mass in the operative site. The patient expired on September 21, 1960.

At the autopsy a large tumor, measuring 8.5x5x7 cms., was found in the right temporal lobe. The tumor was firm and lobulated. On sectioning, it contained extensive areas of hemorrhage and necrosis. Other findings were bronchopneumonia and generalized arteriosclerosis. No other neoplasm was encountered.