CASE 11

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Ref. No.: A-59-705 - N-687

A 7 year old colored female admitted on March 5, 1959 with anorexia, abdominal pain, frontal headache, insomnia, generalized weakness, polydipsia and recurrent vomiting since November 1958. Estimated weight loss, 30 pounds. Birth, neonatal period and development were normal. Present weight 29 pounds; height 46-1/2 inches. Head circumference 40 cm. Emaciated, with loss of subcutaneous fat. Head, chest, lungs, heart, abdomen, lymphatic system, musculo-skeletal system, external genitalis and rectum were normal. Neurological: Alert, oriented. Cranial nerves: intact. Normal fundi. V.A. 20/200 OS 20/100. Motor - normal, except generalized muscle wasting. Sensory examination and cerebellar tests, normal. Reflexes, normal.

She maintained her weight between 28-32 pounds. She received fluids, tube feedings, and soft oral diet with occasional vomiting. On March 6, during fasting state she convulsed. Blood sugar was 11 mg.%. Average urinary output was 800-1400 per 24 hours. On April 13, she developed bilateral VIth nerve palsies, right pupil fixed to light and bilateral papilledema. Ventriculography and surgery on April 17. Postoperatively she remained alert; EOM palsies persisted. Irradiation begun on May 1 and continued until the day of her death for a total dose of 2250r. She became comatose on May 11, 1959 and died within two hours.

Laboratory: CBC and urine normal. Fishberg: maximum urinary concentration of 1.006. X-rays: hands for bone age normal. Spot films of sella normal. Skull films showed separation of sutures. Ventriculogram: dilated nondisplaced lateral ventricles. Aqueduct and 3rd and 4th ventricles not visualized.

Gross: On coronal section an irregularly shaped, multilobular hemorrhagic mass occupied the 3rd ventricle and was intimately adherent to the walls of the hypothalamus. Total measurement approximately 2.5x3.0 cm. Choroid plexuses and ependyma were stained a pale tan color.