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Reprinted from ANNALS OF RHINOLOGY, LARYNGOLOGY AND OTOLOGY, February, 1898.

A CASE OF ABSCESS OF THE TEMPORO-SPHENOIDAL LOBE PRESENTING UNUSUAL FEATURES. — OPERATIONS. — RECOVERY.

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William Reid, aged 28, admitted August 30, 1895, to Dr. Buller's ward, Royal Victoria Hospital.

History.—Six years ago patient's ear first troubled him. It suppurated and left a permanent perforation of the membrana tympani. Since that time his ear discharged occasionally. Present trouble dates from July 1, 1895, when symptoms of pain, raised body temperature, headache, attracted attention to the mastoid, which was tender and presented evidence of suppuration, at one time so superficial that his doctor wanted to incise in the expectation of reaching pus without entering the bone.

Condition on Admission. — August 30 — Considerable redness and tenderness over mastoid, and inflammatory condition extending into neck. A free purulent otorrhea. Suffered considerably with headache, but rested fairly well at night.

September 1—Dr. Buller trephined the mastoid, but was unable to find pus, although going as far forward as the tympanum.

September 2—Intense headache. High fever, 104°. Vomiting and beginning delirium.

September 4—Delirious in a quiet way. Vomited six times. Retraction of head. Neck quite rigid.

September 5—Photophobia, stupor and subsultus tendinium.

September 6—Same, with short shrill cry every few minutes.

September 7—Less crying. Less headache. Disposi-

tion entirely changed from that of a particularly quiet, modest man to that of an extreme boaster.

September 8—Pulse become slow (60). Temp. down, 99½. Dull mental condition. About this time paralysis of left side of face noticed. Retraction of neck still marked.

Transferred to Dr. Bell's Care.—September 9—Was in the following condition:

A tall, thin young man of wiry build, with a condition of intelligence improved from what it had been for a few days, but still noisy and talkative at ti es, wanting to get up, etc.; but can answer questions quite rationally. Severe headache on right side. Fundi normal. Movements of face weak on left side; retraction of neck prevented flexion of head. Noticed for first time, on morning of 9th, that the power of the left arm was almost gone—extensor paralysis at wrist with very weak flexion; at elbow very poor flexion with fair extension. Sensation impaired all over left arm. Power in left leg unimpaired. Pulse 50 to 60. Respiration normal. Over right mastoid region is the wound of first operation. Syringing through auditory canal causes flow of fluid from mastoid wound. There is subsidence of the inflammatory condition which had existed in neck below tip of mastoid, but with slight tenderness still remaining.

Operation.—September 9. Mastoid incision continued upward to parietal eminence, and an incision at right angles to it, passing forward from its center. Small piece trephined away one inch above zygomatic ridge, and opening enlarged by rongeur forceps. On opening through dura mater a flow of pus occurred (over ℥ 1). Rubber drainage tube inserted, and was brought through skin in front of ear. Trephine tore away a branch of middle meningeal artery, from which hemorrhage was found difficult to control; forceps were left applied. A few sutures with iodoform gauze drain from behind.

September 10—Slept well. No pain. Can raise forearm and partially flex fingers. Face improved.

September 11—Rested well. Paralysis of extensors of wrist almost gone. Can flex elbow and extend it; can raise arm from shoulder.

September 12—Paralysis almost gone. Slightly restless. Dressing. Tube aspirated showed brain matter. Some pus drained out along forceps.

September 16—For past three to four days patient has been drowsy most of the time, though at times is cranky, difficult to manage, wanting to get out of bed, etc. Answers questions rationally, but takes a long time to do so. Restless at night lately. Second dressing; forceps removed and tube shortened.

September 19—Patient has been restless at night and drowsy in morning; objects to being disturbed. Headache continuous; bowels much constipated. Quite rational, except on matter of getting up. Muscular power in arm and face quite restored.

September 21—Excessive headache past two days. Slow cerebration. Difficult to rouse now.

September 23—During past night delirious. Tore off dressing. Headache. Prominence noted at dressing.

September 24—Quieter night. Beginning optic neuritis.

September 28—Optic neuritis advancing in both eyes. Severe frontal headache past two days in mornings. Quite rational. With all this, no rise in temperature.

September 29—Pai less night. In afternoon became again delirious.

September 30—Dull and stupid. Pulse 48. Respiration 11.

Third Operation.—Wounds reopened and two abscess cavities found in temporo-sphenoidal lobe, one very small, the other about the size of a walnut. Rubber drainage tube inserted and attached to skin.

October 3—Has been sleeping every night and is quiet and free from pain. Pulse 88. Temperature up a little.

October 10—Has slept from 9 to 6 every night. No pain. Mental condition normal now.

October 13—Tube removed.

November 4—Discharged, with small sinus still present at lower end of wound. Has steadily improved in mental and general condition.

Bacteriology.—Cultures from abscesses at both operations showed pure growths of the streptococcus pyogenes.

Readmitted.—January 17, 1896—Complaining of having had a fit a few days ago, and of a discharging wound in line of old scar.

History.—Since leaving hospital sinus has persisted in front of ear, with slight daily discharge, of late markedly

less. Three weeks ago a small fragment of bone came away through small opening in line of scar behind ear: after this it closed up. After going home he was nervous and irritable for three weeks, but improving all the time. Since then he has done light work in the store, but no mental work.

On Tuesday, the 14th inst., after a heavy meal,, he fell down suddenly in a fainting condition and was unconscious for some time. Vomiting followed, and headache. Felt well since. Patient thinks his mental condition fully as good as ever it was, but his mother finds him more hot-headed and self-willed than formerly.

Present Condition.—Small sinus. Probing reveals several small loose fragments of bone. No tenderness.

Operation.—January 28—Sinus enlarged. Finger introduced enters cranial cavity and feels contracted remains of old abscess cavity. Long tube introduced well within cranial cavity.

January 29—Felt splendid all morning. Slight nausea at noon and vomiting at 2 p. m. At 2:45 p. m. became suddenly livid without any warning and went into a short tonic spasm (almost opisthotonus), followed rapidly by clonic convulsive movements of legs, then of arms. Deep cyanosis. Patient turned on left side. Pulse 120, and regular. Slight frothing at mouth. Pupils slightly dilated and equal. Lasted two minutes. For ten minutes after breathing was very stertorous and noisy, and patient in deep coma; tongue protruding; spitting. At 3 p. m. vomited. At 3:30 p. m. conscious, rational, and feeling splendid. During same evening another similar attack. On February 2 another slight one, without loss of consciou s ness.

March 7—Tube removed; discharge now very slight.

March 21—Has been feeling well all along. To-day without prodromata, another fit, similar to former, and with conjugate deviation toward right side.

April 7—Discharged. Sinus still discharging pus, but presumably from superficial tissues.

N. B.—Dr. Keenan saw patient June 30, 1897. Latter says his memory is a little weak, *e. g.*, can act as floor-walker in store, but not as clerk. Had only had one fit during summer of '96; none since then.