

Résumé

Un cas de lobectomie droite du foie pour hémangiome caverneux massif de ce lobe est présenté. La symptomatologie ainsi que la technique opératoire sont décrites. Les suites ont été marquées par un état fébrile dû à un épanchement purulent teinté de bile et de sang du plevre droit, épanchement qui se tarit par quelques ponctions suivies d'injections d'antibiotiques dans la cavité pleurale.

Les tests hépatiques effectués sept mois après l'opération sont presque identiques à ceux d'avant l'opération et démontrent une légère atteinte de la fonction hépatique. Au point de vue clinique la patiente se porte bien.

Summary

A case of right hepatic lobectomy for massive cavernous hemangioma is presented. Symptomatology and also operative technic are described. Post-operatively the patient developed fever due to a bile stained right purulent pleural effusion which cleared up with few aspiration-punctures and local injection of antibiotics.

Hepatic function tests carried out 7 months after the operation were identical with those obtained before the operation. Clinically the patient seems quite well.

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RECURRENT ATTACKS OF RAISED INTRACRANIAL PRESSURE

in case of

TUBERCULOUS ARACHNOIDITIS.

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I believe the following case is interesting enough to be recorded. T.R. a girl of 13 was transferred from the Children's Hospital, Bongah Nikokari to the Neurosurgical Department of Pahlavi Hospital in March 1959. Three years previously she had been suffering from headache for two months. Apparently no cause was found and she recovered spontaneously. A year ago she again had headache for two months for which she was admitted to a local hospital, and again no diagnosis was made, and she recovered spontaneously. Third attack of headache began ten days ago, for which she was admitted to the Children's Hospital. She was then suffering from severe frontal headache with vomiting. There had been slight neck rigidity. Mantoux reaction was positive. There had been slight fever. Cerebrospinal fluid had been normal... Erythrocyte sedimentation rate was only 3 m.m. On the fifth day of admission bilateral papilloedema was observed. X-ray of skull and chest were normal. On the eighth day of admission headache suddenly subsided, and she felt quite normal. As the patient's history was suggestive of a colloid cyst of the 3rd. Ventricle, she was transferred to the Neurosurgical Department.

On examination patient was alert and co-operative. There was marked bilateral papilloedema, and a left sixth nerve paresis. Otherwise the examination was negative. Patient had no complaint except for diplopia. She stated that she had had the same trouble with previous attacks and got better each time. Urine was normal. Blood picture- 3,800,000 red cells and 8,800 white cells. 68% polymorphs, 2 eosinophils and 30 lymphocytes. Sedimentation rate was 2 mm. X-ray chest was normal, but a left cervical rib could be seen.

Ventriculography. Large subarachnoid spaces. Both lateral ventricles were small, as though compressed from the sides. Examination of the ventricular fluid did not show any abnormality.

Papilloedema rapidly subsided and patient was discharged with a diagnosis of recurrent attacks of external hydrocephalus of unknown aetiology.

She was readmitted a month later with headache, vomiting and papilloedema, and mental confusion. Three days after admission headache suddenly subsided and her condition rapidly returned to normal. This time patient was not discharged, and was kept under observation. Her general condition that had been poor at the second admission steadily improved. 3 weeks later her headache returned suddenly with vomiting and mental confusion.

Ventriculography was repeated and this time it showed moderate internal hydrocephalus.

It was thought advisable to explore the posterior fossa in the hope of finding a correct diagnosis. This was carried out on 18th. May 1959. There was a large arachnoidal cyst situated in the midline extending from below the level of atlas to the middle of the vermis. Cerebella tonsils were small and separated. The wall of the cyst was milk white in colour and in places more than 2 mms. in thickness. Fluid from the cyst and a piece of the cyst wall was sent for examination. This fluid contained 1.20 grms. of Albumin per litre, 9,600 red cells, 38 polynuclears and 36 lymphocytes per cmm. There were no tubercles on the surface of exposed cerebellum.

Examination of the cyst wall was reported by Professor Rahmatian as follows: This is a fibrous tissue which on its surface granulation can be seen, infiltrated with lymphocyte and epitheloidal cells, and occasional plasmocytes. In two places it has taken a follicular aspect, and in one of them a giant cell can be seen. Diagnosis:- Follicular tuberculoid. Figs. 1 & 2.

On this report patient was put under antituberculous treatment with streptomycine, P.A.S. and isoniazids. She had good progress, and on her discharge a month after operation was symptom free. Her parents were told to carry on with her antituberculous treatment.

On 18th. September 1959, exactly 4 months after her operation she was readmitted with 5 days history of headache, vomiting and unsteadiness. As she had been feeling quite normal her medical treatment had been neglected. This time treatment was of no avail, and she died 10 days after admission.

Autopsy Findings.

(Professor Armin)

Brain weight 1350 gm. From optic chiasma to medulla a thick milky membrane was present, with some granulation tissue. Over the pons the thickness of this membrane is more than 3 mms. Over the convexity of the hemisphere this membrane is present but very much thinner. Tubercles can be seen over the occipital lobes. Around the vessels, arteries as well as veins, this thick membrane is very marked.

Microscopic examination of the meninges, especially over the cerebellum where the abnormality is more marked there is inflamma-

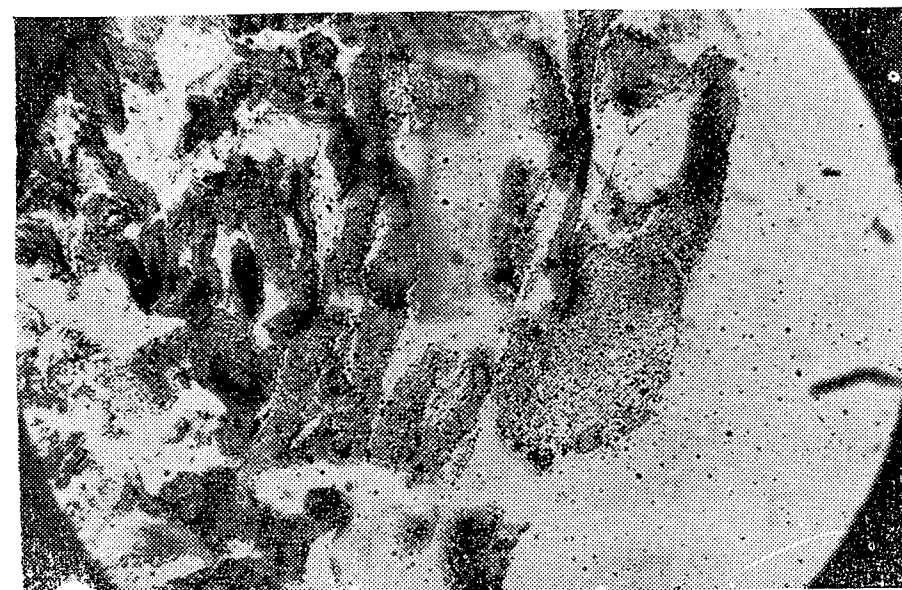


Fig 1

tion with necrosis. Inflammatory reaction is diffuse with great deal of round cell infiltration around dilated vessels, with follicular formation and endarteritis. There is actual cellular infiltration of the cerebellar substance. (Lymphocytes and Giant cells).
Diagnosis: Tuberculous Meningitis.

Discussion.

This case from the beginning had many unusual features which made the diagnosis difficult. At no time had there been a

clinical picture of meningeal irritation, except for slight neck rigidity noticed at one occasion. Normal cerebrospinal fluid, and normal sedimentation rate had also confused the issue. What is really most interesting and difficult to explain is repeated attacks of raised intracranial pressure occurring over a period of three years, with spontaneous "recovery". There is no doubt that except for the last 2 attacks, the others had been in the nature of external hydrocephalus. (Ist. ventriculogram). The cause of this must be sought in disturbance of venous drainage of the brain. This could be either due to thrombosis of the veins or sinuses, or pressure on their walls. Marked inflammatory changes in the meninges around the vessels all over the brain seen at

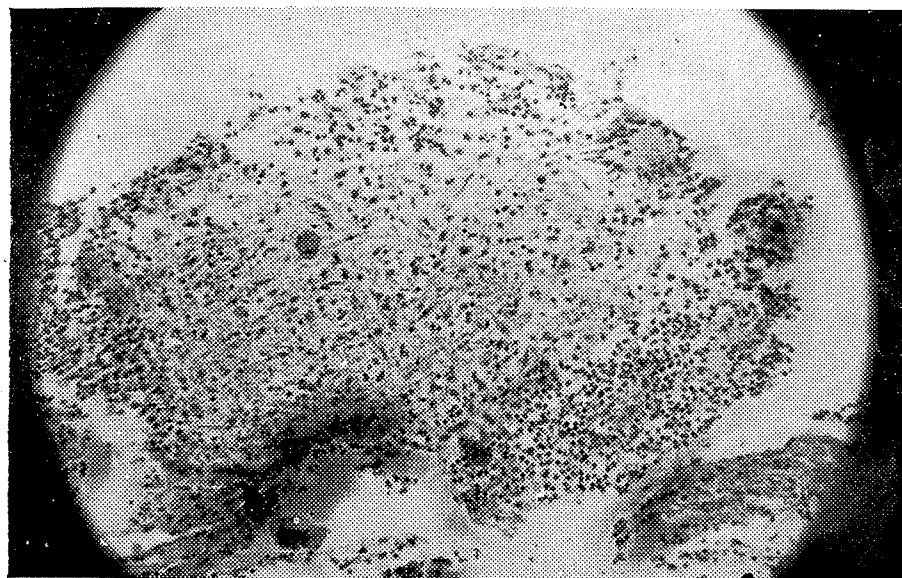


Fig 2

autopsy is in favour of the latter supposition. But why sudden disappearance of the headache? This can only be explained by theorising that for some reason inflammatory process would subside, and thus allow the normal absorption of cerebrospinal fluid. Finally when inflammatory changes of fibrous tissues formation had gone too far, the process which had caused this hydrocephalus had become irreversible. There is no doubt that the final picture seen at post-mortem had not been present at the time of operation. Operative findings

of sever arachnoiditis, with no macroscopic evidence of tuberculous meningitis, but at autopsy presence of large number of tubercles over the surface of cerebellum were unmistakable.

Summary

A case of recurrent raised intracranial pressure is described. At operation posterior fossa arachnoiditis was found. Histological examination suggested a Tuberculous etiology. Four months after the operation she died from an apparently acute tuberculous meningitis.

Résumé

Un cas d'hypertension intracranienne recidivante est decrit. A l'opération on trouve une arachnoidite de la fosse posterieure. L'examen histologique suggère une étiologie tuberculeuse. Quatre mois après l'opération la patiente décède apparemment d'une meningite tuberculeuse aigue.