to mention only those most frequently used. Equally important in the treatment of actinomycotic brain abscess is the adequate evacuation of purulent material, once the infection has become localized, either by excision or drainage.

SUMMARY

An apparent cure of actinomycotic brain abscess is described through the use of surgical excision and antibiotics. Nocardia asteroides was the causative organism. The patient remains well 2 years after surgery.

REFERENCES


UNUSUAL RECOVERY FOLLOWING MARKED DISLOCATION OF LUMBAR SPINE

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Recovery of function following spinal trauma that involves the cauda equina may often be of marked degree. Operative exploration and decompression of the nerve roots in the lumbar region are frequently indicated following trauma, in contrast to lesions that involve the spinal cord at higher levels.

The reason for reporting the case here presented is to demonstrate that despite excessive deformity and displacement of the vertebral bodies, relatively good recovery may take place, emphasizing the importance of using all possible therapeutic measures in patients with lesions of the cauda equina.

CASE REPORT

The patient, a young woman aged 22, was injured Feb. 7, 1947, in a fall from the front seat of a car when the door flew open while going around a corner. She was temporarily unconscious but upon awakening noted complete paralysis of both lower extremities and severe pain in the lumbar spine. There was also a complete loss of sensation below the waist subjectively.

X-rays taken following the injury showed a very marked lateral displacement of the 1st lumbar laterally on L2, almost the full width of the body. There was also a slight forward displacement of L1.

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Neurological examination 4 days after the injury revealed a complete flaccid paralysis of both lower extremities and a marked sensory loss below the inguinal region. The sensory loss was not complete. Some sensation was perceived as far down as the 4th lumbar root distribution. Also in the lower sacral region some sensation was present, particularly over the saddle area. There was complete areflexia in the lower extremities. There was no sphincter control.

Spinal puncture revealed a complete block in the spinal canal. The fluid was xanthochromic.

1st Operation. A decompressive laminectomy was done Feb. 12, 1947. The lamina of the inferior portion of D12 and the 1st and 2nd lumbar laminae were removed. There was a laceration of the dura mater on the left side with extrusion of one root filament which was caught in the fracture site at the region of the articular facet on the left. The root was replaced and the dura mater was closed.

Orthopedic consultation during the laminectomy was obtained and an attempt was made to manipulate and effect reduction of the dislocation, but without any improvement of the position of the vertebral bodies.

Course. Following surgery there was a slight gradual improvement in sensation over the lumbar and sacral roots.

Follow-up x-rays taken Mar. 30, 1947, revealed complete over-riding with a displacement of the L2 body upward to a point slightly higher than L1, which had occurred while the patient was flat in bed (Fig. 1).

Skeletal traction was then applied through both femurs with 20 pounds on each leg. Only slight alteration in the position was obtained, as shown in Fig. 2. In view of this fact it was decided to perform another operation.

2nd Operation, May 1, 1947. Inspection of the dural sac revealed it to be making a very sharp turn at the level of the dislocation, but as a result of the decompressive laminectomy the structures had accommodated fairly well and the dura mater was pulsating. No further bone was removed. Fusion was then done, using screws and bone grafts, as shown in Figs. 3 and 4.
Course. Subsequently, the patient showed a gradual improvement in motor function and sensation. In January, 1948, she had regained bladder control, and had no dribbling, urgency or frequency. There was further motor improvement, particularly in the upper leg on both sides. By March, 1949, she was able to get around with braces and was doing her own housework. Bladder and bowel control were good and sexual functions were normal. The chief motor deficit was in the anterior tibial muscle groups on either side. Improving strength allowed her to discard her braces with the exception of some improvised rubber foot-drop supports which she used in preference to the usual standard type.

She was seen again in November, 1953. There still was practically no function in the anterior tibial group. She had fair power in the calves on both sides, and had good quadriceps and hamstring function. Knee reflexes had returned. Ankle jerks remained absent. There was still some sensory loss over the L5 and S1 root distributions primarily. Other sensation was essentially normal, sphincters were entirely normal, and there was no back pain despite her deformity.

Subsequently she obtained employment and at the present time is working regularly as a telephone operator and radio dispatcher. She is able to walk about the latter office without support, but in walking outside she uses short crutches to maintain her balance (Fig. 5).