was caused by a basilar arachnoiditis. While I had never encountered this situation in a child so young, it seemed a logical assumption at the time. That the infected ear was an adventitious finding, and that cerebellar neoplasm might be obliterating the basilar cisterns was not thoroughly considered simply because of the child's age.

CONCLUSIONS

While brain tumors during the neonatal period of life have rarely been reported, they should be kept in mind when evaluating infants with signs and symptoms of an intracranial disorder. Persistent vomiting should direct suspicion to the head when a clear-cut demonstration of gastro-intestinal pathology is not present.

In hydrocephalic infants who vomit persistently and who have an increased protein content of the ventricular fluid, a tumor is very likely, and an air study should be carried out. Using a small amount of air, the procedure is safe. A greater awareness will undoubtedly lead to more frequent antemortem diagnosis.

SUMMARY

There has been presented a third reported case of a medulloblastoma occurring in an infant of the neonatal period. It appears to be the first reported instance in which a posterior fossa neoplasm was demonstrated by means of a ventriculogram in a child of this age. Findings that suggest intracranial tumors in early infancy are discussed.

REFERENCES


INTRADURAL LIPOMA OF THE SPINAL CORD

ROBERT M. N. CROSBY, M.D., JOHN A. WAGNER, M.D., AND POMEROY NICHOLS, JR., M.D.*

Department of Neurosurgery and Department of Pathology, Division of Neuropathology, University of Maryland School of Medicine, Baltimore, Maryland

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Two reports have appeared in the recent literature describing cases of intradural spinal lipoma. In both cases operation was performed, but the tumor appeared to be intramedullary and so only a palliative procedure was done. About the time these articles appeared, a similar case was observed at the University Hospital. When surgically exposed, the tumor was thought to be intramedullary, but further study

* Present address: University of Georgia School of Medicine, Augusta, Georgia.
suggested its benign, extramedullary nature so that at a second operation, a successful attempt at total resection was made. Because the second operative procedure revealed the true extramedullary position of this lipoma, it was agreed that a report of the case with detailed operative findings was indicated.

A review of the literature concerning intradural spinal lipoma by Ehni and Love\(^1\) in 1945 listed 29 detailed cases and mentioned 10 or 12 more in which insufficient data were given. Of all these cases, in only 5 was the tumor surgically resected: 1 by Root, 1 by Sachs and Fincher, 2 by Elsberg, and 1 by Ehni and Love. Eight more cases were reviewed by Johnson,\(^2\) in 4 of which resection was performed. Taniguchi and Mufson\(^3\) reported 1 case in which the tumor was not resected, bringing the total to over 48. The case presented here, we believe, is the ninth reported case in which an intradural lipoma of the spinal cord was totally resected.

CASE REPORT

M.J., a 31-year-old negro female, was first examined in the out-patient department of the University Hospital in August, 1950.

She dated the onset of her present illness to April, 1950. At that time, while 8 months pregnant, she had experienced back pain in the low thoracic and lumbar regions and noted weakness in the left leg and numbness of the left foot. Following delivery, there was a steady progression of weakness, stiffness, and numbness which began to involve both lower extremities. During the last month of her illness, she could not walk without support. She also had nocturia of 2–3 times and urgency of urination. In the first week of August, 1950, she had burned her buttocks with a hot water bottle without any sensation of pain.

Examination. The patient was an apparently healthy colored female. Tenderness was noted on pressure over the spinous processes of the lower thoracic vertebrae. The left leg was 1–2 cm. smaller in circumference than the right at all points measured. There was about 60 per cent loss of motor power in all muscle groups of the left leg and about 30 per cent loss on the right side. Moderate increased resistance to passive motion was noted, more on the left than the right. Superficial abdominal reflexes were absent. Patellar and Achilles tendon reflexes were markedly hyperactive in both legs. The response to plantar stimulation was flexor on both sides. There was diminished pain and thermal sensibility throughout all the lumbar and sacral dermatomes on both sides and hyperesthesia in the 12th thoracic dermatomes bilaterally. Position sense was lost in both lower extremities. Walking was extremely difficult even with a cane and was accomplished on a wide base by keeping the knee and ankle joints stiff.

Roentgenograms of the chest and spine were interpreted as showing no abnormality. Blood serological test for syphilis was negative. Clinical impression: lower thoracic spinal cord tumor. Myelography confirmed the presence of an intraspinal tumor.

1st Operation, Oct. 17, 1950. The spinous processes and laminae of the 7th, 8th, 9th, 10th and 11th thoracic vertebrae were removed. The dura was incised and a large yellow mass protruded into the opening. This mass was apparently in the spinal cord with the pial vessels continuous over it. The swollen cord filled the entire canal so that the dorsal roots could not be visualized. Normal spinal cord was seen above and below the mass, which measured about 10 cm. in length. At the site of the tumor itself, however, no demarcation from recognizable spinal cord could be seen. A dorsal midline incision was therefore made into the yellow mass. Several pieces of tumor were removed by sharp dissection, without any evidence of neural tissue. The tumor was firm and homogeneous but appeared spongy on the cut surface. The dural defect was covered with a saline-moistened Gelfoam\(^4\) and the wound was closed without drainage.

Postoperative Course. There was no motion in the lower extremities for the first 5 days and there was complete loss of bladder control for the first week. She improved rapidly and had regained her pre-operative neurological status at the end of 4 weeks.

Pathologic Examination. Gross. The fragments of tumor removed were soft, slightly fibrous and yellowish. The cut surface was homogeneous, glistening, and fatty.