The numerous eponyms and terms that have resulted from the study of sarcoidosis over the years reflect the protean clinical manifestations of this disease entity. Historical reviews reveal that in 1875 the first clinical report of a case was made by Hutchinson. In 1889 Besnier designated the skin changes "lupus pernio." Boeck (1899) described the histologic features of the cutaneous lesions and introduced the term "sarcoid." Heerfordt (1909) reported the uveoparotid fever syndrome, which later became identified as a manifestation of sarcoidosis. Schaumann (1914) was first to recognize the systemic nature of the disorder and suggested the term "benign lymphogranuloma." Osseous lesions, previously recognized by other observers, were established as part of the generalized disease by Jüngling in 1919.

Though extensive investigations as yet have failed to determine the etiology of sarcoidosis, clinical aspects have advanced impressively, and the cutaneous, visceral and lympho-hematopoietic manifestations have become well established. Neurologic expressions of the disorder, not widely appreciated, are of particular interest. Involvement of the nervous system is relatively uncommon, and intracranial sarcoidosis simulating brain tumor is decidedly rare, only one case being cited by Essellier, et al. in their extensive review of the literature in 1951. Additional cases of sarcoid tumor were recorded by Everts in 1947 and by Höök in 1954.

The present report is concerned with the successful surgical removal of a solitary, circumscribed intracranial tumor resembling a meningioma from the floor of the middle fossa. It was identified histologically as a sarcoid granuloma.

**CASE REPORT**

**History.** A negroid male, aged 19, on active duty in the U. S. Navy, was admitted to the hospital on July 18, 1954, because he had suddenly lost consciousness while aboard ship.

His illness began in July, 1953, when he was bothered by a roaring noise in his right ear. This was continuous and occasionally associated with headache and slight vertigo. In January, 1954, he was hospitalized for treatment of an infection of the right ear, and it was noted that he had polyps in the right external auditory canal. His symptoms continued and he returned to the hospital in April, 1954, when the polyps were surgically removed.

He then began to suffer from almost continuous right-sided headaches with intermittent nausea and vomiting. In addition he had frequent, brief episodes of slight mental confusion associated with unpleasant olfactory hallucinations. Distinct feelings of familiarity occurred at times, even when he was in a strange environment. In the month prior to admission he had two spells, characterized by automatic behavior with subsequent amnesia for his actions. He was found walking aimlessly about the ship, seemingly in a dazed state, and when attempts were made to restrain him he reacted in a maniacal, belligerent manner and finally lost consciousness.

* The opinions or assertions contained herein are the private ones of the authors and are not to be construed as official or reflecting the views of the Navy Department or the naval service at large.

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Examination. General physical findings were normal. Neurologic examination revealed bilateral papilledema of 4 D. There were small hemorrhages about both discs. Visual fields showed enlarged blind spots. The remainder of the cranial nerves were intact. The motor system showed good power throughout, although on prolonged repetitive movements the left extremities fatigued sooner than the right. There was mild increase in muscle tone in the left extremities. Coordination was normal. Sensation was unimpaired. The deep tendon reflexes were active and equal except that the left quadriceps response was slightly greater than the right. Plantar stimulation produced flexor responses of the toes bilaterally. The left superficial abdominal reflexes were consistently less active than the right.

Routine blood studies and urinalysis gave normal findings. Blood serology was negative. Roentgenogram of the chest showed no abnormalities. Skull roentgenograms revealed an enlarged sella turcica with demineralization of the clinoid processes. Lumbar spinal puncture showed a pressure of 280 mm. of clear CSP. The fluid contained no cells; sugar was 45 mg. per 100 cc., chloride 128 mEq. per liter, globulin 3+, and total protein was 100 mg. per 100 cc.

Electroencephalogram was disturbed by gross focal changes, consisting of higher potentials, slow activity of 1 1/2 to 4 per sec. frequency, irregularity of form and asynchrony which appeared in the anterior temporal, mid-temporal and low frontal areas on the right side (Fig. 1). Right percutaneous carotid arteriography revealed displacement of the middle cerebral artery upward and to the left, indicating the presence of a mass in the right temporal area (Fig. 2).

Operation. Craniotomy was performed on July 26, 1954. The tumor was not immediately evident on the surface of the temporal or posterior frontal lobes but was located by use of the Selverstone-Robinson probe counter, the patient having received intravenous radioactive phosphorus the previous day. Counting in the right temporal lobe delineated an area in which there was a ratio of 70 to 100:1 counts which extended from directly below the middle temporal gyrus medially for a distance of about 5 cm. Removal of a small portion of the inferior right temporal lobe revealed the tumor lying on the floor of the middle fossa. The mass was about the size of a goose egg, measuring 7×5×5 cm., and extended medially almost to the mid-line. Removal of the tissue was accomplished by punch and electrocautery loop. The

![Fig. 1. Electroencephalogram showing high voltage slow activity in the right temporal and low-frontal areas.](image-url)