TRAUMATIC HEMORRHAGE FROM THE
ANTERIOR CHOROIDAL ARTERY*

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Several years ago we had under our care an individual who had sustained a head injury, who we were certain had a traumatic intracranial mass lesion, upon whom we did many and varied diagnostic studies, but who progressively deteriorated and died without benefit of diagnosis or appropriate treatment. His case history follows.

Case 1. W.J.S., 52-year-old white male, was admitted to the Baltimore City Hospitals on Aug. 14, 1952, after having been found unconscious on the street. There was a laceration of the scalp in the left parieto-occipital region and there was the odor of alcohol on his breath. He was deeply stuporous, with miotic and equal pupils. His blood pressure was 130/75, pulse rate 90, and respiratory rate 18.

Three hours after admission there were spontaneous movements of the left upper and lower limbs and occasionally turning of his head to the left. There was no response to spoken voice. He moved his left upper and lower limbs in response to painful stimuli. The fundi appeared normal. Anisocoria was present, the right pupil measuring 4 mm. and the left 2 mm. The right pupil was irregular and did not react to light, whereas the left pupil reacted well. Moderate right central facial weakness was present and the corneal reflex was somewhat depressed on the right. No superficial abdominal reflexes were elicited. The right plantar response was extensor and the left flexor.

Hemoglobin was 14 gm. and blood serology was normal. Urine was normal except for 4 plus albumin. On August 16 nonprotein nitrogen of the blood was 34 mg. per cent and the albumin-globulin ratio was 4.8/2.9.

On the day after admission his state of consciousness improved. He was still confused and his speech was garbled. The right corneal reflex was depressed and right hemiparesis persisted with depression of the deep tendon reflexes. Sensation over the right side of the body appeared normal. On August 16 he was allowed up out of bed and his state of consciousness as well as his hemiparesis gradually improved. By August 20 only a minimal right hemiparesis persisted, but there was still a diminished right corneal reflex and he remained confused and disoriented as to time and place. Lumbar puncture on August 20 showed an initial pressure of 80 mm. with clear and xanthochromic fluid. There were 11 red blood cells and 1 white blood cell. The total protein was 70 mg. per cent and the spinal fluid serology was normal. Roentgenograms of the chest showed pleural thickening and of the skull were normal except for pansinusitis.

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During the next few days the patient became progressively more drowsy and because of the persistent mild hemiparesis and deteriorating state of consciousness, bilateral temporal trephines were done on August 26. In the left subtemporal region approximately 10 to 20 cc. of slightly xanthochromic fluid were evacuated from the subdural space. There was slight bulging of the temporal cortex at time of closure. Bilateral parietal trephines were made and approximately 60 cc. of ventricular fluid, which appeared to be under slightly increased tension, were removed and replaced with a similar amount of air. The ventriculograms showed slightly dilated lateral ventricles with inadequate filling of the third ventricle (Figs. 1 and 2). It appeared that the third ventricle as well as the inferior aspect of the body of the lateral ventricles were shifted slightly to the right (Fig. 1). A percutaneous left carotid arteriogram done on September 2 showed no definite abnormality (Figs. 3 and 4).