The term "hemangioblastoma" was proposed by Cushing and Bailey. They used the term to include the lesions that they considered true neoplasms of vasoformative cells; and to separate these from venous angiomas, arterial angiomas, and telangiectasias—which they considered angiomatous malformations. They based this dichotomy on the absence of glial tissue between vascular channels in the true neoplasms, as contrasted in the presence of glial tissue in the vascular malformations.

The choice of the word "hemangioblastoma" was unfortunate. As Silver pointed out, it "... conveys a false conception of malignant potentiality and primitive structure." Cushing and Bailey (p. 303) thought that these lesions were almost all cerebellar, admitting that some of the solid lesions formed in the cerebrum and spinal cord probably represented this entity. Whatever the faults of the word "hemangioblastoma," it was well defined by its originators and attempts at renaming these lesions lead only to further confusion. This is especially true since a large percentage of these lesions in the cerebellum are found as mural nodules of large cystic lesions, and this classical picture is automatically associated with the term "hemangioblastoma" in the mind of the neurosurgeon and pathologist.

Over the years hemangioblastomas have been recognized with increasing frequency, and in other sites within the central nervous system. Hemangioblastomas have been found within the cerebrum, the spinal cord, and the medulla.

Two of the authors (M. S. and A. S.) recently reported a surgical decompression into the fourth ventricle of an intrapontine cyst. The patient expired 4 years after operation but before publication of the case report. A short addendum with the autopsy findings was included but no specific diagnosis was given. The gross and microscopic findings were those of a typical cystic hemangioblastoma. We have been unable to find a reported case of this lesion occurring in the pons. It is interesting that in reporting the clinical case the authors were unable to find a similar case and postulated a posthemorrhagic cyst as the etiologic factor.

The reader is referred to the case report for a detailed clinical story. A brief summary is included since the operation performed upon the patient 4 years prior to his death had some bearing on the pathological findings.

CASE REPORT

M. C., a 41-year-old white male, had several admissions to Temple University Hospital with symptoms suggestive of a pontine lesion. In October 1956 he was admitted in a comatose condition. He had increased cerebrospinal fluid pressure with choked discs. One of the authors (M. S.) performed a decompression, and shortly after, a suboccipital craniotomy. The floor of the 4th ventricle was elevated and bluish. The elevated area was incised. Golden-yellow fluid ran out and solidified rapidly. The cephalad limit of the cyst was marked with a silver clip, and another clip was dropped into the cavity.

The patient showed some improvement postoperatively. Then his condition remained unchanged for a number of years. He died suddenly on May 29, 1960. His terminal episode was not observed.

The family was reluctant to permit an autopsy, but finally consented to a removal of the involved tissues through the original incision.

The incision revealed an extradural cavity approximately 12 cm. in diameter containing clear cerebrospinal fluid under high pressure and lined by a glistening membrane. A small round opening 2.5 cm. in diameter led intracranially into the subtentorial area and through this opening the dilated lower half of the 4th ventricle was seen. The ventral surface of the pons was soft and adherent to the occipital bone and the cisterna pontis was obliterated. There was no evidence of any recent intracranial bleeding. The final specimen consisted of a small portion of the spinal cord, the medulla, pons, and some cerebellar tissue.

On the dorsal surface, 1 cm. cephalad to the tip of the calamus scriptorius, the medulla measured 2 cm. in width and 1.5 cm. in depth. The lower half of the 4th ventricle was visible because of a chronic elevation of the cerebellar tonsils by a huge cisterna magna, secondary to back pressure of cerebrospinal fluid from blockage of the cisterna pontis by the enlarged pons. The elevated floor of the 4th ventricle compressed, but did not completely occlude, the ventricle. A cystic grape-like mass attached to a pedicle and containing orange colloidal material appeared to have herniated from the cephalic portion of the 4th ventricle or the pons.

The basilar and vertebral vessels and branches appeared normal, with no evidence of aneurysm, hemorrhage, arteriosclerosis, or infection. The pons was enlarged, measuring 4.5 cm. in width and 4.5 cm. in length.
from the end of the calamus scriptorius to its cephalic limit.

The pons was cross sectioned 2 cm. rostral to the tip of the calamus scriptorius, revealing a huge 4th ventricle and the wall of a large midline cyst (Figs. 1 and 2) which involved the tegmentum as well as the midportion of the pons, and extended more to the right side than to the left. The top of the wall of the cyst was adherent to the roof of the 4th ventricle in the midline. The opening made into the cyst through the floor of the 4th ventricle, at the time of operation, was seen. The silver clip was found within the cyst, which was now devoid of fluid. A small bluish mural lesion, approximately 1 cm. in diameter, was present on the right side of the basis pontis. The nodule, on sectioning, appeared vascular and was felt to be the source of the xanthochromic fluid evacuated previously. The cystic cavity was 3.5 cm. in length, 2.5 cm. in width and 1.5 cm. in height when held open in its natural shape. It involved the tegmentum and middle portion of the pons in the caudal half and dipped into the basis pontis in its cephalic portion. A measurement was taken of the remaining tissue in the basis pontis at the middle half of the pons and at a point where the small bluish mass was found adjacent to the wall of the cyst. Eight-tenths of a cm. of tissue remained on the right between the external surface of the pons and the wall of the cyst adjacent to the mural nodule, and 1.8 cm. remained on the left side between the surface of the pons and the closest point along the wall of the cyst.

Microscopic sections of the mural nodule showed a central portion made up predominantly of cavernous channels (Fig. 3). These channels were lined by a single layer of endothelial cells and were separated by hyalin-