The general and neurological examinations were essentially negative. X-ray examination revealed complete recalcification of the sella turcica (Fig. 5).

COMMENT

The original infestation in this case probably took place in the United States inasmuch as calcification of other larvae was present at the time of operation, which was only about 18 months after his arrival in Egypt. As a general rule, calcification does not occur for from three to six years after infestation.

The diagnosis was not made preoperatively. On review of the x-ray films of the chest, the calcified areas noted in the mediastinum are still indistinguishable from calcified nodes. The patient gave no history of symptoms suggestive of the disease. This is not uncommon as the tissues are quite resistant to live larvae, and it is only after they die that a more intense local reaction occurs. If there are subcutaneous lesions, a common occurrence, the presence of palpable pea-sized nodules together with recovery of the adult worm in the stool makes the diagnosis evident. In their absence, however, diagnosis is difficult until calcification has occurred.

The cyst presenting was associated with the leptomeninges. It was impossible to accomplish the ideal, the removal of all the cyst wall, because of its inaccessibility. Inasmuch as there had been no evidence of recurrence nine months after operation, it is assumed that this particular cyst has been eradicated. When convulsions or other signs of central nervous system disease develop in an adult who has served with the armed forces in the Middle East and India, a diagnosis of cysticercosis must seriously be considered.

SUMMARY

1. A case of cysticercus cellulosae of the brain is presented with surgical removal and with no evidence of recurrence nine months afterward.

2. Inasmuch as many men will be returning from foreign soil where Taenia is prevalent it is important to keep this condition in mind when signs and symptoms of central nervous system disease develop.

REFERENCES


A NEW POSITION FOR FRONTAL CRANIOTOMY*


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Recently in considering the surgical exploration of the circle of Willis for a suspected aneurysm, it seemed worthwhile to try a new method of approach in the hope of improving

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visibility in the region about the optic chiasm. A head rest was developed (Fig. 1) which securely held the head in such a position that the floor of the anterior fossa was in a horizontal rather than vertical plane. The patient was placed on his abdomen with the neck extended so that the patient's face was toward the surgeon (Fig. 2), much as one would lie on the floor to read with the face held between the hands. The position proved so satisfactory that we have continued to employ it for all operations in the frontal region (Fig. 3). In spite of the unorthodox method of fixation of the head and the hyperextension of the neck, there has been no postoperative complaint of soreness of the face or stiffness of the neck.

The conventional position for transfrontal craniotomy is with the patient's head resting on the occiput with the face up. In spite of the apparent success of this method through the years, it is not difficult to find obvious technical disadvantages that can be improved by altering the position of the patient's head. In the conventional position, as the skin and bone flaps are reflected they must be turned upward and anchored to the drapes. When wrapped in