ANEURYSM OF THE INTERNAL CAROTID ARTERY ASSOCIATED WITH HYPOTHALAMIC FITS

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Aneurysms involving the circle of Willis are of common occurrence. In spite of their frequency, it is seldom that one attains unusual size, and it is a decidedly rare occasion when the history is found to extend over a period of 25 years. In Dandy’s recently published work comprising 133 aneurysms, one case only covered a 22-year history, although there were several others in the age group of 10 to 17 years.3

The most unusual feature about the aneurysm described in the present report was not associated with its longevity or size, but rather concerned its influence on the hypothalamus. In Dandy’s large series there was no case that in any way gave evidence of derangement of the functional activities of this center.2

CASE REPORT

A white 53-year-old veteran was admitted to the hospital on March 13, 1944. He complained of “severe headache over the right eye, trouble with his eyes, and fainting spells.” The onset occurred 25 years previously in 1919 while serving with the armed forces in France. At that time he received a minor injury to his head, and, although dazed, was not knocked unconscious. He was able to recall a severe headache localized to the forehead and was of the opinion, but not certain, that he saw “double” with his left eye tending to turn out. At any event diplopia did occur, but whether instantly or over a period of time could not be stated definitely. Sometime later he experienced what he referred to as “fainting spells.” These spells were characterized by a feeling of drowsiness which would rapidly increase in intensity, terminating in unconsciousness. There were no convulsive seizures associated with these episodes. The duration of the attacks varied from a few minutes to an hour or more.

At the beginning, these “attacks” were not particularly frequent, probably averaging four or five a year. The progression of symptoms was gradual. The headaches became more severe; the “fainting spells” more frequent; and the left eye pulled further to the left. The vision, particularly of the left eye, became greatly impaired. For the six months previous to admission the headaches were unusually intense and frequently shifted to both temporal regions. The “fainting spells” were longer in duration and occurred at least once a day.

The other relevant history was that of a penile lesion acquired while in the Service. It was not a proven chancre, and antiluetic therapy was never given.

Examination. The patient was a rather poorly developed and poorly nourished chronically ill white male. He was rational and oriented, but exhibited some evidence of memory impairment. His gait was normal, but he walked with obvious fatigue and his head was tilted and fixed to the right.
Neurological examination showed the following positive findings: There was atrophy of the left disc, but fingers could be counted at several feet. The right disc was slightly blurred. The left 3rd and 4th cranial nerves were paralyzed (Fig. 1). There was complete sensory and partial motor impairment of the third division of the left 5th cranial nerve as well as a right central facial weakness. The peripheral reflexes were present and equal throughout, but on the hyperactive side. There were no pathological ones present. The Romberg test was negative. There was some clumsiness of the left arm, and left past pointing was fairly marked.

Laboratory tests, including the serology, were within the normal range. Spinal fluid examination was not done.

The x-ray report of the skull stated that there was an extensive calcification in a cyst wall occurring above and posterior to the sella, displacing the tip of the dorsum downward and forward, and situated chiefly to the left of the midline. Three distinct lobes of the cyst could be seen. The total width of the tumor mass was almost 6 cm. (Figs. 2 and 3). The x-ray opinion was craniopharyngioma.

Course. The patient’s hospital course was marked by increasing severity of headache and “fainting spells.” On observation these “spells” were characterized by an initial feeling of weakness and faintness. These aura were usually of sufficient length to enable him to reach his bed before unconsciousness intervened. This was accomplished without attracting attention, and other patients on the ward were totally unaware of the impending attack. He would simply climb on his bed, lie down quietly and, after carefully supporting his head, slip into deep unconsciousness. There was no evidence of motor involvement. Rapidly the color would become pale; the skin cold and clammy; the pulse weak and, at times, almost imperceptible. The blood pressure always fell from an average of 130/70 to 100 systolic or below, and on several instances it was necessary to give the patient supportive intravenous therapy.

At the termination of these periods of unconsciousness, the patient was frequently, but not always, confused. Within a few moments complete orientation returned and the only evident effect was the ever present headache.