leg and was then placed over the gelfoam. The bleeding was satisfactorily controlled and the wound was then closed. Postoperatively, the patient had a left homonymous hemianopsia which disappeared on the 5th postoperative day. Otherwise the course was uneventful. Her headaches markedly improved. When last seen on May 1, 1947, she was asymptomatic.

COMMENT

The site of this calcified aneurysm is in the same location as in the reported cases of arterio-venous aneurysms of the vein of Galen. Alpers and Forster’s case also had some calcification in the aneurysm wall. Our case, however, lacked the hydrocephalus noted in the others. The hydrocephalus in the reported cases was believed due to obstruction of the iter by the vascular mass, and not to obstruction of blood flow through the vein of Galen. Our case would tend to prove that the explanation of the hydrocephalus occurring in the other cases is correct since, although the vein of Galen was probably involved, the aqueduct was not obstructed and, therefore, no hydrocephalus existed. A lesion at this site not producing hydrocephalus would cause few symptoms, as was true in our case. Had we recognized the nature of the lesion on the roentgenograms, we would probably have withheld operation. Yet, as it turned out, the patient was relieved of her preoperative headaches, perhaps as a result of thrombosis of the lesion. This would leave the question of the indications for operation in the absence of hydrocephalus an open one. If hydrocephalus is present, however, some short-circuiting operation should be done.

SUMMARY

A case of calcified aneurysm lying between the occipital lobes and probably representing an arterio-venous aneurysm of the vein of Galen and branches of the circle of Willis is presented. The patient’s only symptom was headache, which was relieved by operation.

A review of the literature of similar reported cases is given.

REFERENCES


RADIAL PALSY ELASTIC SPLINT

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Various ingenious wrist-drop splints have been devised and described in this last war. All have disadvantages. Description is here made of an elastic splint permitting full mobility of the fingers and hand in cases of radial nerve palsy. Photographs and a line drawing are

* 56 Garden St., Hartford, Connecticut.
† Constructed by the “brace shop” of The Cushing General Hospital, Framingham, Massachusetts, in 1945.
presented to illustrate its construction. The wrist cuff can be worn either proximal or distal to the head of the ulna.

Its advantages are as follows: (1) All joints can be used. (2) Elastic bands duplicate the physiological action of extensor tendons. (3) Finger cuffs attach to the proximal phalanges (the ulnar nerve innervates the extensor tendons of the terminal digits). (4) Finger tips are left uncovered for use. (5) A glove may be worn over the splint in cold weather. (6) A coat or jacket can be put on without removing the splint. (7) Tension is adjustable for each finger and the thumb. (8) Ulnar or radial deviation can be counteracted by twisting the wrist cuff. Its disadvantage lies in the necessity for painstaking construction, especially in the proper padding of the wrist cuff with sponge rubber, and in the fitting and tapering of the finger cuffs to prevent chafing of the interdigital webs. When properly constructed and intelligently worn, it has proved invaluable to those patients and physicians desirous of early mobilization of wrists and fingers.

A children’s adaptation is much simpler in construction and applicable to all young patients regardless of their intelligence or cooperation. It is constructed from a child’s size, cotton mesh glove with hook-eyes sewn on the dorsal surface of the proximal finger and thumb joints and a corresponding number of hook-eyes sewn to the dorsal wrist of the glove. A wide “elastoplast” cuff is then applied to the patient’s wrist. The wrist of the glove is then