tissues usually found in the external or middle ear. Further investigation of these areas will ultimately have to be done to confirm this hypothesis. Another mode of invasion into the cranial cavity possibly may be malignant degeneration of the tumor and subsequent erosion of the bone. However, there was no definite histologic evidence of malignancy.

SUMMARY

A case is reported of the intracranial occurrence of a ceruminous adenoma which heretofore has been reported as occurring only in the external or middle ear. The tumor was found extradurally in the region of the left internal auditory meatus where it produced a destruction of the petrous portion of the temporal bone, and a paralysis of the 7th and 8th nerves.

REFERENCES

3. Bailey, P. Personal communication.

PAPILLOMA OF THE CHOROID PLEXUS

REPORT OF CASE

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Papilloma of the choroid plexus is a relatively rare intracranial tumor. Less than 100 of these tumors have been reported, and the majority of these were disclosed at autopsy. As far as we have been able to determine from the literature, only 24 papillomas have been diagnosed surgically and of this group less than half the patients survived the immediate postoperative period.
PAPILLOMA OF THE CHOROID PLEXUS

From a pathological standpoint papillomas of the choroid plexus are generally regarded as benign tumors. However, cases are recorded in which histologic evidence of malignancy was present. Secondary tumor implants have been observed as well. In addition, a tendency to recurrence following apparently complete extirpation has been noted.

REPORT OF CASE

A 20-year-old white female was admitted to the medical service of the N. C. Baptist Hospital on Nov. 18, 1946 complaining of headache of 6 months’ duration. This was mainly frontal and retrobulbar in location and was accompanied by gradually progressive blurring of vision. At times, when headache was particularly severe, there had been nausea and vomiting. She also had noted from time to time diplopia, vertigo, and scotomata.

Examination. The patient was alert, cooperative, and in no acute distress. Positive findings were: bilateral chronic papilledema, weakness of the external rectus muscle on the right, generalized muscular hypotonia with depression of the tendon reflexes, and marked ataxia. Routine blood and urine studies were within normal limits. Blood serology was negative. Skull films were normal. Visual acuity was 20/40 in each eye. Visual fields showed minimal generalization of constriction with gross enlargement of the blind spots bilaterally. Vestibular studies suggested a midline posterior fossa lesion.

The patient was transferred to the neurosurgical service.

Operation. On Nov. 29, 1946, ventriculography was carried out. This disclosed dilatation of the lateral and 3rd ventricles with a complete obstruction at the distal portion of the aqueduct.

A suboccipital craniectomy was performed immediately under general anesthesia. Following the usual operative exposure, which included resection of the posterior arch of the atlas, it was seen that the cerebellar dura was under extreme tension. Ventricular tap relieved the tension to an extent that a dural flap could be reflected without difficulty. The vermis was considerably widened and its folia were obliterated. Projecting from the foramen of Magendie was a tongue of reddish papillary tumor tissue which almost completely filled the cisterna magna. Additional exposure of the tumor mass was attempted by a midline incision into the cerebellar vermis, which proved to be only a few mm. in thickness. Immediately, an irregular cauliflower-like mass, some 4 or 5 cm. in diameter, extruded itself from the 4th ventricle. Considerable hemorrhage occurred at this point both from the surface of the tumor and from the tumor bed. The tumor was lifted from the field without finding a point of attachment. In retrospect, it seems likely that the vascular connections were torn when the tumor mass extruded spontaneously. In any event, as soon as the tumor was removed, bleeding abruptly stopped except for one or two small points in the roof of the ventricle. These were easily coagulated and the field was observed to be dry.

Inspection of the 4th ventricle revealed a tumor nodule, 3 mm. in diameter, firmly implanted in the floor of the ventricle. It was felt that this nodule could not be successfully removed in view of its location and attachment. No other bits of tumor could be seen. Fluid could be seen flowing from the distal end of the aqueduct. The dural flaps were then replaced but not sutured and the wound was closed in the usual manner. The patient was returned to the ward in fairly good condition.

Pathological Report (Dr. W. C. Thomas). "An irregular mass of tissue measuring 4 x 4 x 3 cm. The tissue externally is made up of a grayish-yellow to a grayish-pink type of material, having no definite architectural features. The tissue is found to be easily fragmented and very friable. On attempting to section this tissue, it fragments into numerous pieces, and fragmented portions of this tissue are submitted for sectioning.

"On microscopic examination, this tissue is seen to be made up of many small papillary processes supported on a delicate fibrous stroma containing small capillaries (Fig. 1). The papillary processes are made up of cells which appear to be low columnar or tall cuboidal type cells, and the characteristics of most of the nuclei are similar, although one sees an occasional nucleus which is small and dark. Diagnosis: Papilloma of Choroid Plexus."