REFERENCES


THE SYNDROME OF BRAIN ABSCESS WITH CONGENITAL CARDIAC DISEASE

REPORT ON A CASE WITH COMPLETE RECOVERY

AARON J. BELLER, M.D.

Neurosurgical Department, Rothschild-Hadassah University Hospital, Jerusalem, Israel

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Brain abscess associated with congenital cardiac disease is a very uncommon finding. Wechsler and Kaplan,7 in a review of the subject, collected 12 cases from the literature and added 2 of their own. They pointed out that in only 1 of the previously reported instances was a diagnosis made during life; all the others were accidental autopsy findings. Reports on the subject have been added by Hanna,3 and by Vann and Miller.6 Robbins4 found 3 cases of brain abscess in a group of 53 patients with fatal congenital cardiac disease. In his comprehensive report (1945) he comments: “Brain abscess is a relatively unrecognized complication of congenital heart disease, . . . so little, that only rarely does one find reference to it in any standard textbook of medicine . . . . In all probability, this apparent obscurity and paucity of reported cases represent the failure either of their recognition or of their publication rather than the rarity of their occurrence.” A case in which the diagnosis of abscess of the brain was made and the patient cured surgically was placed on record by Smolik, Blattner and Heys.5 Among the very recent reports were those of Gates et al.1 and Hand.2

The following is a description of a case showing this syndrome.

REPORT ON A CASE

S. K., a 6 1/2-year-old boy, was admitted on Aug. 16, 1948, because of convulsive seizures of Jacksonian type of 10 days' duration.

Family history was irrelevant except for the fact that the boy's parents were cousins.

Past history was significant in that a diagnosis of congenital cardiac disease had been made at the age of 3 months. The child had been under constant medical care since that time. In his infancy he had suffered from frequent “colds.” He had pneumonia twice, at the age of 3 and
at the age of 5. He had measles at 3 and chickenpox at 4. A tonsillectomy had been performed at the age of 4. The boy was known to be unable to stand any physical strain because of easy fatigability and dyspnoea, with subsequent cyanosis.

On August 6, 10 days prior to admission, the boy fell down the stairs while playing. Half an hour later, while talking to his mother, jerking movements began in his right arm and leg, he turned blue in the face, and then lost consciousness. He regained consciousness "after several minutes" but remained paralyzed in the right arm and leg for 3 to 4 hours, after which the paralysis cleared up completely. A second seizure, which followed the same pattern, came on 2 days later, again with complete recovery from paralysis after several hours. During the following week there were repeated episodes of jerking movements in the right arm, which occasionally spread to the right leg, without loss of consciousness. The patient was seized with a third convulsion 2 days prior to admission. This time after regaining consciousness he remained paralyzed in the right extremities, vomited, was very apathetic and refused to eat. According to his mother, he showed difficulty in speaking after the last attack.

Examination. The boy appeared acutely ill, and was very irritable and uncooperative. Pulse rate, respiration and temperature were normal. Significant findings were: moderate deree of cyanosis, clubbing of the fingers, enlargement of the heart with a thrill and a loud harsh systolic murmur over the entire precordium, most pronounced in the right 3rd intercostal space. The retinal veins were slightly engorged, with normal disc margins. There was right central facial weakness. There was paralysis of the right upper and lower extremities with exaggerated hyperactive tendon reflexes and Babinski sign on the same side. The abdominal reflexes were absent and the cremasteric reflex was diminished on the right side. There seemed to be diminished pinprick appreciation on the right side.

Laboratory findings: Urine: normal. Blood culture: negative. Blood count: RBC 5,200,000; hb. 12 gm.; hematocrit 42; WBC 12,800; neutrophiles 68 per cent, lymphocytes 26 per cent, monocytes 6 per cent. Urea: 24 mg. per cent. Sugar: 104 mg. per cent. Total protein: 5.8 per cent.

X-ray of the skull did not reveal any abnormality.

On radiologic examination the heart was sandal-shaped and the apex rounded and elevated. There was a concavity at the pulmonary segment. The hilar markings were increased with transmitted pulsation. The intravenous angiocardiology showed immediate and simultaneous filling of the aorta and the right heart. The left heart was not filled until the seventh second film. The pulmonary artery trunk was not outlined but its branches were