HEMANGIOBLASTOMA WITH POLYCYTHEMIA


HEMANGIOBLASTOMA OF CEREBELLUM WITH POLYCYTHEMIA

CASE REPORT

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Neurological signs and symptoms are frequently associated with primary polycythemia due to the vascular complications characteristic of this disease. Conversely, instances of intracranial neoplasms with an associated secondary polycythemia have been reported in the literature.

The occurrence of expanding subtentorial lesions with polycythemia is extremely rare. Oppenheimer3 reported a case of polycythemia and cerebellar medulloblastoma. Two cases of hemangioblastoma of the cerebellum and polycythemia were reported by Carpenter, Schwartz, and Walker.4 Both of their patients had remission of the polycythemia following removal of the hemangioblastoma. An excellent review of the literature on neurogenic polycythemia was given by Drew and Grant5 in 1945. They added 1 case, the intracranial lesion being a subdural hematoma. The polycythemia in their patient, however, showed signs of returning after 5 months.

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CASE REPORT

C.M., aged 24, a second lieutenant in the infantry, was admitted to the U. S. Army 70th General Hospital on Aug. 9, 1944. He had been evacuated from the 29th Station Hospital and was flown from Algiers to Oran. On admission, he was conscious but spoke very slowly and in a monotonous tone. P. was 60/min., R. 11/min; B.P. normal. He seemed well oriented but was not alert. When taken by litter to the x-ray department, he began to scream with pain and afterwards complained of persistent severe headache. Later in the evening he became very drowsy and stuporous, but improved slowly after intravenous administration of 50 per cent glucose. The next morning he had projectile vomiting. The officer who had accompanied him from Algiers stated that the patient had deteriorated mentally over a period of about 4 months and particularly during the 7 days before admission.

The patient’s illness began in October, 1943, with severe throbbing occipital headaches which persisted. For the last few months he had noticed difficulty in reading, blurring of vision, and diplopia. He had been troubled by dizziness and stumbling, particularly to the right, and there seemed to be some slowing of his speech. He had been in another general hospital in January, 1944, and in a station hospital in February 1944 with the chief complaint of headache. He was discharged both times with a diagnosis of psychoneurosis. He was readmitted to the 29th Station Hospital on Aug. 2, 1944. A lumbar puncture was done there and following this he became much worse, being stuporous a good deal of the time.

Examination. He was a moderately drowsy but easily aroused individual talking in a monotonous tone. There was some aphasia, ataxia, or asynergism. He had nystagmus right and left, and marked bilateral papilledema with exudate. There was a right facial weakness with hypesthesia. The tendon reflexes were slightly hyperactive on the right. Babinski reaction was present bilaterally. There was incoordination of the arm and hand with past pointing with both hands. Heel-to-knee tests were performed fairly well.

RBC was 4,790,000; Hb. 13.5 gm. (90 per cent). Leucocyte and Schilling counts were normal. Clotting time was 7 min.; bleeding time, 3 min. X-rays of skull were negative.

1st Operation. On Aug. 9, 1944, preliminary ventriculography through the right posterior horn (80 ml. of fluid removed and replaced with air) showed a dilated ventricular system with a large 3rd ventricle. Cerebellar craniotomy was then done. After the dura had been opened over both cerebellar hemispheres and the occipital sinus ligated and cut, a cystic tumor was seen in the left hemisphere, extending down into the cerebellar tonsil. The cyst was evacuated. Then, using lighted retractors, it was completely explored, but no nubbin of tumor or evidence of hemangioma was found.

Postoperative Course. The patient did very well. Two lumbar punctures were done because of slightly bloody CSF, but otherwise his course was uneventful. He was evacuated to the zone of interior, and was given a medical discharge from the army.

Subsequent Course. He was asymptomatic in every respect until 1948, when he wrote that his symptoms were beginning to reappear. Accordingly, we advised him to enter the U.S. Veterans Hospital at Jefferson Barracks, Missouri. He was admitted on June 11, 1948. He had been entirely well until about 2½ months previously, when he first suffered persistent, dull headaches, partially controlled by headache powders. Following this he noticed a return of visual disturbances, particularly difficulty in focusing. There was a tendency to stagger on walking and true vertigo on leaning forward. The symptoms were especially prominent during the last 2½ weeks.

Examination. Positive neurological findings were: nystagmus on looking to the right, markedly positive Romberg test, and staggering gait. Fundoscopic examination by the ophthalmological consultant revealed no abnormalities.

RBC was 7,890,000; Hb. 21.1 gm. (136 per cent); hematocrit cell volume per cent 69. Leucocyte count was 6,850, with normal Schilling count; platelet count was 645,000. Repeated RBC was 7,820,000; Hb. 21.9 gm. (136 per cent). Kahn reaction was negative.

Roentgenograms of the skull showed only the old cerebellar craniectomy wound. Films