day following his first operation, the temperature rose to 99.2, and then varied from 96.4 to 98 with a pulse averaging 70 and respirations 20. Only on the day of discharge did the temperature reach 98.6. There was this evidence of continuous disturbance of the heat-regulating center which became more pronounced during the periods of the hypothalamic fits. There was no clinical evidence of any anterior hypothalamic irritation or destruction. Although the tuber cinereum was crushed and thinned, functionally it remained intact and there was not the least indication of disturbance of fat, carbohydrate, or water metabolism. There were no emotional crises nor was there any evidence of mental instability. The patient's emotions were always under control, and although his general picture was one of dullness and sleepiness, this was not borne out by his mental response.

The question is raised by these episodes, which might be classified as a type of autonomic epilepsy, as to whether there is not a distinct relationship between surgical shock and elimination by depression alone of the posterior hypothalamic nuclei. It is conceivable that a vast flow of impulses instigated by trauma could be a sufficient reason for fatiguing these nuclei and thereby initiate the rapid development of shock.

CONCLUSION

The clinical and anatomical record of a large sacculated aneurysm of the internal carotid artery of 25 years' duration has been presented. The clinical manifestations of associated hypothalamic fits have been discussed. The intimate relationship of the posterior hypothalamic nuclei and surgical shock has been suggested.

REFERENCES


PINEAL TERATOMA: REPORT OF CASE

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(Received for publication September 1, 1945)

Tumors of the pineal body remain puzzling lesions from the standpoint of their origin, their true nature and proper designation, their potentials for endocrine disturbance and their treatment. Teratomas have been invested with especial interest principally because of

* Since this paper was written, Dr. Ehni has entered the armed forces and is now Lieutenant (jg), Medical Corps, United States Naval Reserve.
the unsolved problem of the relation of this type of tumor to the syndrome of macrogenitosomia praeeox. Bochner and Scarff have provided a recent review of the literature of these particular tumors in reporting a case of their own. They found 13 tridermal and 4 bidermal tumors and, in addition, 10 tumors that they considered to be compound or mixed tumors similar to certain tumors of the salivary glands. Since the mode of origin of all these tumors is beclouded and since Hosoi's classification of certain of these tumors conflicts with Bochner and Scarff's, the latter's distinctions with regard to certain of these tumors may be artificial and McLean's larger collection of teratomas may come closer to representing the true total of tumors of this particular type. McLean found 26 tumors that he considered to be teratomas. He did not include one case of teratoma and one case of teratoid mentioned by Bochner and Scarff. Zeitlin's teratoma (case 1) seems to have escaped Bochner and Scarff and should be included, as should the case reported by Ragan. Certain additional cases have been reported recently. Baggenstoss and Love in their case 4 and Russell in her case 2 reported what may be other examples. The Quarterly Cumulative Index Medicus contains references to certain other reports which were not available. Thus, it seems that more than 33 teratomas, teratoids and mixed tumors have been observed.

A patient who had a pineal neoplasm was recently under my care at the Mayo Clinic.

**REPORT OF CASE**

The patient, a youth aged 18 years, registered at the Mayo Clinic on March 28, 1944. Because of the nature of his complaints he was hospitalized immediately. His reason for coming to the clinic was headache. He stated that on Feb. 15, 1944, he began to have intermittent bilateral frontal headaches which at first lasted for 3-3 days and which became progressively more severe. Three weeks prior to registration, the headaches became constant and were made worse by sudden movement of the head and by straining. The headache never awakened him but it often prevented him from going to sleep. Some time after the headaches began, he noted giddiness and nausea and soon after the onset of these symptoms he began to vomit intermittently. He was hospitalized elsewhere and spinal puncture was done which revealed an increase in the intraspinal pressure. For a few weeks prior to registration at the clinic, he experienced weakness and intermittent numbness in the left leg and more recently there had been some vague diminution in visual acuity.

His left eye had been removed after an injury at the age of 4 years. Both parents were living and well, as were eight brothers and one sister. The patient had had no previous significant diseases.

**Examination.** He was a well-developed and well-nourished young man with the significant findings limited to the nervous system. Examination of the cranial nerves revealed no defect except for inability to elevate the remaining eye more than slightly above the horizontal. The patient stated that attempts to elevate it further caused pain in the orbit. The visual acuity of the eye was 14/21; the pupil was large and reacted neither to light nor in accommodation. A rough examination of the visual fields revealed no defect. Examination of the ocular fundus showed acute chocking of the disk amounting to an elevation of 3 diopters. There were hemorrhages around the disk and some small ones beyond the macula. The veins were moderately engorged. The muscles of the left calf were slightly weakened but all other muscles possessed normal strength and tone. All tendon reflexes were equal and of normal intensity. There was no disturbance in sensation nor defect in coordination or in gait.

Routine examinations of blood and urine gave negative results. Roentgenograms of the head disclosed a considerable amount of calcium lying in the region of the pineal body. An electro-encephalogram disclosed bilateral delta activity in the occipital regions which was interpreted as being due to a lesion in the posterior fossa.

On April 1, 1944, the patient had persistent vomiting with twitching and clonic movements of both legs. The fingers of the right hand became numb but feeling returned intermittently. Diagnoses entertained at one time or another by those observing the patient were: right parasagittal lesion in the central area, lesion of the posterior fossa, and lesion of the midbrain.