When he returned on Nov. 14, 1946, he said that he had not had any symptoms except occasional mild headache and transient numbness of the right hand. On Dec. 12, 1946, a bilateral frontotemporal tantalum cranioplasty was done by one of us (E. N. W.). The post-operative course was uneventful.

**SUMMARY**

Bilateral extradural hematoma is a rare condition. Bilateral chronic subdural hematoma is relatively common. We feel that the importance of bilateral exploration in cases of acute injury of the head has been emphasized by the case that we have reported.

**REFERENCES**


**ELECTRICAL BURN OF THE BRAIN**

W. James Gardner, M.D.

*Cleveland Clinic, Cleveland, Ohio*

(Received for publication August 26, 1947)

The following case is reported to demonstrate a method of treating a contaminated wound of the brain when there is insufficient scalp remaining to permit closure.

**CASE REPORT**

A boy, aged 11, was admitted to Cleveland Clinic Hospital on May 14, 1946. Five days previously while playing “cops and robbers” he had climbed a pole and his head had touched a high tension line carrying 6,000 volts. He was knocked 30 feet to the ground, sustaining a severe burn on the right side of the scalp and lesser burns on the hands and on the dorsum of the left ankle. He aroused from a semiconscious state after 9 hours, when it was discovered that his left arm was weak.

On examination 5 days after injury the patient was comfortable and cheerful. His temperature was 99.4°F. In the right frontoparietal region was an extensive third degree burn of the scalp, the eschar measuring 9 × 12 cm. Where the scalp had been burned away the outer table of the skull was dry and blackened. There was complete paralysis of the left arm and partial paralysis of the left side of the face and leg. There was a left homonymous field defect to gross tests.
ELECTRICAL BURN OF THE BRAIN

Fig. 1. Appearance upon admission to hospital 5 days after burn was received.
Fig. 2. Devitalized bone has been removed. The pale area represents devitalized dura and brain.
Fig. 3. The defect in the bone has been closed with a tantalum plate to immobilize and protect the underlying damaged brain.
Fig. 4. Degree of approximation of the scalp defect accomplished after closure of relaxing incision.

Operation: Debridement and Application of Tantalum Splint. Under pentothal anesthesia on May 14, 1946, a tourniquet was applied by passing several turns of Penrose tubing tightly about the head. The devitalized portion of the scalp was excised, leaving a scalp defect which measured 14×10 cm. The devitalized bone was then removed with a rongeur until normal