

1962

CASE 11

Submitted by: Lt. Richard L. Davis, MC, USN, Armed Forces Institute of Pathology, Washington, D.C.

A 3-1/2 month old male was the product of a normal pregnancy and delivery. The early neonatal period was unremarkable but at age two months a midline mass was noted at the region of the anterior fontanelle. The mass enlarged but no other signs or symptoms were noted.

On physical examination the mass measured 5 cm. in diameter. It was firm, non-tender, non-pulsatile, and fixed to the skull. No bruit was heard. The optic fundi were not well visualized and the general physical and neurological examinations were normal except for a mild mucoid nasal discharge and wheezes and fine rales in both lungs.

Skull x-rays showed the mass in the anterior fontanelle with erosion of the bony margins and separation of the coronal suture line.

A spinal tap showed an opening pressure of 110 mm. of water and clear fluid. The protein was 124 mg.% and the glucose 61 mg.%. Numerous RBC's and a few WBC's, mostly lymphocytes, were present.

A pneumoencephalogram showed bilateral "cerebral atrophy" and carotid angiograms did not show large vessels to the mass.

At surgery the mass was adherent to the underlying dura but did not appear to have penetrated the dura. The child died at the conclusion of the surgery.

At autopsy a small nodule identical to the large mass was found on the internal surface of the dura. No other tumor was present. The excised tumor mass was 5.5 x 5.5 x 4.5 cm. in size, firm, and varied from gray to black in color.

