

CASE 13

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A 42 year old male was admitted to the V.A. Hospital, Augusta, Georgia, 26 days prior to his death. The past history indicated that over a 2 month period, prior to the admission, he had exhibited slight mental aberrations and, on occasion, had black-out spells. When these signs and symptoms first appeared, the patient was seen by a neurosurgeon. An arteriogram failed to reveal any definite lesion at that time. His mental difficulties increased, making it necessary for him to be admitted to the State Mental Hospital. During that hospitalization he first was conscious and cooperative, but later developed a left-sided spasticity with a left facial weakness, focal seizures involving the left lower extremity only, and over the weeks slowly dropped into a severe coma. The past history was essentially non-contributory, but his divorced wife stated that he had behaved erratically for a period of 10 years prior to his death.

Diagnostic studies, many of which were repeated several times, finally suggested the presence of a neoplasm in the region of the corpus callosum. An exploratory craniotomy was planned, but the patient developed cardiac arrest during induction of the anesthesia.

The gross examination of the brain, which weighed 1570 gms., revealed marked edema with pressure marks. There was slight asymmetry of the mammillary bodies. On mid-sagittal section one recognized marked increase in the anterior portion of the corpus callosum (approximately 1.5 cm. in thickness at the widest point) due to a diffuse gray velvety neoplasm. The process spread slightly laterally into both hemispheres and though grossly not recognized, microscopically it involved the entire brain stem down to the level of the pons and medulla. A complete autopsy was performed, but a similar process was not noted in any of the other organs of the body.