CASE 2

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The patient was a 66-year-old woman who was a known hypertensive for the past 25 years. Otherwise, she was well until 11 months before death, when she had a mild febrile illness ("flu") associated with headache, nausea and vomiting. She recovered, however, during the next few months. She had two brief episodes of lethargy and confusion. Spinal fluid examination at this time was normal, protein 28 mg.%. Five months before death, she was admitted with a history of personality changes ("she became forgetful and was living in the past"), periods of alternating lucidity, irrationality and confusion. The patient was discharged with a diagnosis of "chronic brain syndrome" and hypothyroidism, etiology unknown.

Three weeks prior to death, she fell and struck her forehead. She was again admitted, this time in comatose condition, with dilated pupils which reacted sluggishly to light. Arteriograms showed a questionable shift of the anterior cerebral artery from left to right, hydrocephalus and atheromatosis of the anterior and middle cerebral arteries. Brain scan was normal. EEG, on the other hand, was considered abnormal and indicative of diffuse C.N.S. disease. Spinal fluid showed normal opening pressure, protein of 123 mg.% and a colloidal gold curve: 5555321000. Repeat spinal tap one week later showed opening pressure of 248 mm H_2O and 240 mg.% protein. The patient was transferred to another hospital where she died.

Autopsy showed no significant changes in the organs except for slight atrophy of the thyroid and adrenal glands. Examination of the brain showed a grey-white, flat, disc-shaped mass involving the floor of the third ventricle, obliterating the ventricle in this area. The greatest diameter of the mass was about 3 cm. No other anomalies were found in the brain.

H & E stained slides and a gross Kodachrome of the brain lesion are distributed. The diagnostic problems will be discussed at the meeting,