

CASE 5

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This 18 year old male was first seen at John Sealy Hospital February 1960. History revealed that during the previous 5 weeks he had noted the onset of diplopia, frontal headaches, vomiting and lethargy. Physical examination revealed bilateral papilledema, paralysis of upward and lateral gaze, and decrease in visual convergence. His gait was unsteady and he would stagger to the left and to the right. Skull films were negative, but ventriculograms demonstrated bilateral dilatation of the lateral ventricles with a large indentation into the posterior portion of the third ventricle and compression of the aqueduct.

5 days later a Torkildsen procedure was done. Post-operatively he received x-ray therapy totalling 5,025 r which was administered in multiple doses over a six week period.

Following dismissal from the hospital he did well until May 1960 when he suddenly developed severe frontal headaches. Examination revealed bulging of the operative site, and a ventricular puncture provided temporary relief. However, 2 days later, the patient suddenly became apneic and expired.

The brain weighed 1399 gms. The gyri were flattened and there was narrowing of the sulci. A midline section revealed an irregular, grayish-white tumor mass in the region of the pineal gland which measured 3x3x2 cm. The colliculi were depressed and neoplastic tissue appeared to be invading the tectum, rostral mesencephalic structures, and the posterior part of the third ventricle.