Clinical and other Notes

A CASE OF ACROMEGALY SHOWING ENLARGEMENT OF THE PITUITARY FOSSA AND GIVING A SHORT HISTORY OF ONSET.

CAPTAIN BY T. O. THOMPSON.
Royal Army Medical Corps.

Pte. T. B., aged 25, service 4½ years. Admitted to Hospital, Bangalore, May, 1919, complaining of loss of vision of the left eye for nine months.

History.—
Family History.—No trace of any condition resembling acromegaly or bearing on the disease in any way.
Past Medical History.—No illness of any kind, which he can remember, before joining the Army.

Present Medical History.—Sand-fly fever, August, 1917, in Mesopotamia.
In August, 1918, he had a very severe attack of diarrhoea in Mesopotamia, during which on August 3 he had a very bad headache which lasted about one week.
He was sent to see the eye specialist, and attended three or four days, but nothing more was done. He has had the bad headaches eight times since then. There is a very slight ache present at other times. The headaches are very severe spasms of pain, mostly frontal, lasting about four minutes. The loss of vision occurred when the headaches first started, and has been getting worse lately.

On Admission.—Heavily built type of man complaining of loss of vision of left eye.

Eyes.—Right eye, good reaction to light. Left eye, practically no reaction to light; eye movements appear normal. Pupils, equal and regular.

Eye Specialist's Report.—Primary atrophy of the left eye with complete loss of reaction to light on temporal side and slight reaction on nasal side. Right eye vision 2/6, no atrophy, and field appears normal.

Respiratory System appears normal; no obvious enlargement of either the thyroid or thymus gland found.

Circulatory System appears normal. Pulse is slow, soft and regular. Heart, nothing adventitious found.

Alimentary System normal, appetite good; bowels regular. Teeth excellent, few missing.

Urinary System.—Has never noticed himself being puffy or swollen, and has not noticed any swelling of hands or feet. Has never had any urinary trouble. Occasionally gets a slight pain in the left lumbar region unaffected by movement. Has never had any hematuria or renal colic. Testicles appear normal.

Urine.—Contains albumin 1/4 per cent. No casts, no sugar.

Central Nervous System.—No apparent change noticed in speech or hearing. He is of average intelligence, and appears to have no mental defects.

Cranial Nerves.—First nerve: He states definitely that he considers that he cannot smell so well as before. Second nerve: See eye specialist's report. Third and fourth nerves appear normal. Fifth nerve: Complains of pain over the frontal regions on both sides when the headache is present, and also in the left temporal region. No special hyperesthesia or anaesthesia over emerging branches. Sixth nerve appears normal. Seventh nerve: Slight asymmetry of face on movement of grinning. Eighth nerve: Hearing good and appears equal
Clinical and other Notes

on both sides. Abdominal reflexes normal. Knee jerks normal. Elbow jerks normal. Plantar reflexes normal. No ankle clonus. No spastic or paralytic condition or wasting of any muscle found.

X-Ray Examination (see attached photograph).—Lateral view shows marked enlargement of pituitary fossa. The bones of the skull are somewhat thicker and more massive than normal. The actual measurements of the fossa on the plate are twenty-two millimetres antero-posteriorly, twelve millimetres vertically. The appearance suggests that the pituitary fossa is enlarged by a cyst and has pressed on the left side of the optic tract. The actual outline of the bony portion of the fossa is perfectly clear, which seems to point to absence of any invading neoplasm.

Hands and Feet.—The hands and feet are both rather large and massive-looking but the patient had not himself noticed anything until his attention had been drawn to them. His boots had become tighter but he had not had to change the size. In the standing position his fingers hung to within three inches of the knee-joint.

His general appearance is one of heavy build and large bones without any very definitely marked point to go upon. Comparison with an old photograph showed this. As can be seen from the X-ray the jaw is large and solid. As nothing definite could be done for the man here, he was invalided with a view to possible operative treatment in England.

The case appeared to be of interest for the following points:

(1) The Sudden Onset.—This appears to be absolutely definite and to coincide with an attack of acute diarrhoea. The age incidence is the normal one and the onset is often associated with some definite illness such as in this case. The type of illness appears to vary and presumably a condition of generally lowered metabolism may lead to lack of certain essential salts causing a final upset in the metabolism of the pituitary gland and an abnormal secretion of the anterior part.

(2) The Prognosis and Possible Treatment.—No attempt was made to treat with glandular extracts as no certain results appear to have been obtained. As regards operative treatment the earliness of the condition and the small present local change suggest the possibility of cure, but as these cases may live in comparative comfort many years it seemed that symptomatic treatment would be the best.

ACUTE MENINGITIS OF UNCERTAIN ORIGIN.

By Lieutenant-Colonel J. L. Wood.
Royal Army Medical Corps.

This short paper was written at the request of Sir John Rose Bradford, who very kindly took an interest in a number of cases which passed through the hands of several medical officers of the local Isolation Hospital.

As the last of these medical officers, I have embodied their observations in this note. The histories and temperature charts of all these cases have been kept and I believe they were aborted cases of cerebrospinal fever. The cases all came under our observation as suspected cerebrospinal fever; they were characterized by a sudden onset of severe headache not necessarily frontal or occipital; vomiting, a stiff neck, a positive Kernig, pyrexia of varying degree—usually brief, slow pulse,