NOTES ON A CASE OF ANEURYSM OF THE BASILAR ARTERY.

BY CAPTAIN E. W. WADE, D.S.O.
Royal Army Medical Corps.

SERJEANT-MAJOR L., aged 46, was admitted to "Tower Hill" Military Hospital, Sierra Leone, in July, 1921, complaining of headache and loss of vision. There was a history of otorrhoea in the left ear in 1916. No history of syphilis, but the patient had had gonorrhoea twenty-six years previously.

Seven months before admission he had noticed difficulty in walking straight, staggering to the right every few yards; the condition became worse and he began to have headaches which lasted two or three days at a time.

The pain was most severe at the back of the skull and radiated to the eyes and ears.

Three or four months before admission his speech became slurring and indistinct, and about three months before admission his vision became hazy, being worse in the left eye.

On admission he was seen by Captain T. L. Fraser, O.B.E., R.A.M.C., whose notes on this case I am taking the liberty of publishing.

"General condition poor. Headache still present, occurs in spasms and is hæmalgic in character. Point of maximum intensity below the occipital protuberance. Proptosis of left eyeball present. Pupils are unequal, left bigger than right. React slowly to light and accommodation. Left more sluggish than right. No facial paralysis. Dryness of mouth and throat. Speech slurring and indistinct. Ringing present in left ear. Knee-jerks exaggerated, left more than right. Staggering gait, patient falls to the right. Cannot stand with both eyes closed. Is not able to walk along a straight line. Enlarged prostate. Daily catheterization necessary. Hæmorrhoids present. For some time has had some difficulty in micturition, frequency and dribbling. Patient eats and sleeps fairly well."

He was invalided to the United Kingdom as a right-sided cerebellar tumour. Admitted to Military Hospital, Devonport, on February 6, 1922, when I saw him and his condition was as follows:

"General condition poor, headaches still present occurring in spasms with point of maximum intensity below occipital protuberance. Temperature, normal. Pulse 88 to 100. Respirations 18 to 20. Intelligence good, speech slurring and indistinct. Memory for old events good, for recent events not so good. There was no actual paralysis but the right arm and leg were slightly weaker than left. No facial paralysis. No anæsthesia to light touch, pain, heat or cold anywhere over trunk or limbs. Gait rather spastic, especially right leg; drags right foot and always deviates to the right. Pupils very small, equal, re-act to light and accommodation, nystagmus fine to right, coarse to left. Knee-jerks exaggerated especially right. Plantars, right flexor; left not obtainable. Patellar clonus marked on right side, none on left. Ankle clonus marked on right side, none on left. Sphincters normal, no incontinence of urine or faeces. Difficulty of micturition
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from enlarged prostate. There was nothing abnormal in the remaining systems. Urine acid, 1010; albumin, nil; sugar, nil. Blood count showed haemoglobin eighty per cent. Red corpuscles, 5,100,000; white corpuscles, 10,800; polymorphs, 79 per cent; lymphocytes, 15·5 per cent; large mononuclears, 4·5 per cent; eosinophiles, 0·5 per cent; mast cells, 0·5 per cent. Wassermann reaction was negative.

Cerebrospinal fluid showed no trace of globulin, no lymphocytes and no sugar. Wassermann reaction negative. The cerebrospinal fluid was not under increased pressure.

An examination of the ears by the aural specialist showed "definite signs of old inflammation of both ears, especially left. Membranes are both much retracted. No evidence of any active suppuration in either ear. Hearing much reduced in left ear."

An examination of the eyes by the ophthalmic specialist showed "no optic neuritis in either eye; this rules out cerebellar tumour as optic neuritis is an invariable accompaniment of cerebellar tumour; the fundi are normal in every respect."

The surgical specialist did not think an operation advisable as there were no localizing symptoms nor optic neuritis. After admission patient remained in statu quo until February 24, when all his symptoms increased in severity and he had difficulty in swallowing, which became worse, necessitating nasal feeding. He died on March 2, 1922, approximately fourteen months after the appearance of his first symptoms.

At the autopsy the following condition was found. Brain and membranes congested. Aneurysm of basilar artery about the size of a bantam’s egg and involving the circle of Willis. It had caused pressure on and indentation of the pons varolii, medulla oblongata, temporosphenoidal lobe and cerebellum on the left side.

It is interesting to note how the symptoms on the right side changed from those of an irritative lesion to those of a destructive one.

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SOME HINTS ON THE SANITARY EQUIPMENT REQUIRED FOR A BRITISH TRAINING CAMP IN INDIA.

By Captain J. Bryan Fotheringham.
Royal Army Medical Corps.

A Junior Royal Army Medical Corps Officer, new to India, and with no previous service in the East, in most cases will find difficulty in arranging what sanitary equipment the battalion of which he is in medical charge, should take to an Annual Training Camp. The camp site chosen may be at a place which will render it possible for him to visit it beforehand. Often it is quite impossible for the Regimental Medical Officer to examine the camp site chosen prior to going there with his regiment. In that case he has to rely on second-hand information about the local water supply, the presence or absence of incinerators, the diseases prevalent in the locality of the camp, and all geological and topographical details.