

PATHOLOGICAL STUDY of PITUITARY TUMOURS  
ESPECIALLY as regards their TYPES, INCIDENCE and COURSE

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Thesis for the Degree of Doctor in Philosophy  
by  
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PART II  
APPENDIX for CASE-RECORDS

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1925, 12, 15, 1925,  
had 5  
to attacks  
to note.  
for 1 year

I. ADENOMATA.

last 3 years.  
for 3 years.  
of the  
not recovered.

empty.

a disease.  
approach was  
Vitalis

SERIAL NO. 1.  
HOSP. NO. 21. (Mr Dott).  
R.C.P. NO. 8780/29.

MRS J.W.

Examined on 23.12.1925.

Female, aged 40, married for 17 years, had 5 pregnancies (the last 9 years ago), subject to attacks of headache since puberty.

Previous illnesses: Nothing important to note.

C/O:

1. Amenorrhoea since last pregnancy.
2. Undue persistence of lactation for 1 year after weaning.
3. Increase in weight for 8 years.
4. Severe attacks of headache for last 3 years.
5. Gradual deterioration of vision for 3 years.

Paresis of abducens and parasthesia of the ophthalmic division of the trigeminal that recovered.

Positive findings are:

1. Dyspituitarism.
2. Blindness with complete optic atrophy.
3. Ballooned sella turcica.

Clinically diagnosed as chromophobe adenoma.

Partial removal with transphenoidal approach was done on 26.12.25, followed by radiation. Vision improved, menstruation re-established.

Recurrence. /

SERIAL NO. 1 (contd.)

Recurrence. Operation on 27.9.29 (right trans-  
frontal exploration and partial removal).

Histology: Cells: Chief and transitional.  
Arrangement: Sinusoidal. Stroma: Dense fibrous  
tissue with hyaline degeneration.

1. Loss of sexual libido for 3 years.
2. Failure of vision for 4 months.
3. Lassitude for 3 months.
4. Attack of epistaxis 3 months ago.
5. Increase in weight in last 3 months.
6. Headache for 3 months.

Examination revealed that the patient is tall and  
well developed with following positive findings:

1. Dysopituitarism.
2. Acuity of vision diminished to hand movements  
on the left side.
3. Bitemporal hemianopia.
4. Enlarged left optic disc.
5. Sluggish reaction of pupils to light.
6. Enlarged left eyeball.
7. Markable distension of sella turcica.

Diagnosis clinically as: Craniopharyngeal tumour.

Therapy /



SERIAL NO. 2.  
HOSP. NO. 22. (Mr Dott).  
R.C.P. NO. 40/30.

R.S. Admitted on 9.2.1926.

Male, aged 47, married since 16 years, has children (wife's last pregnancy 11 years ago).

No important previous illnesses to be noted.

C/O:

1. Loss of sexual libido for 2 years.
2. Failure of vision for 4 months.
3. Lassitude for 2 months.
4. Attack of epistaxis 2 months ago.
5. Increase in weight in last 2 months.
6. Headache for 1 month.

Examination revealed that the patient is tall and well developed with following positive findings:

1. Dyspituitarism.
2. Acuity of vision diminished to hand movements on the left side.
3. Bitemporal hemianopia.
4. Pallor of left optic disc.
5. Sluggish reaction of pupils to light.
6. Tender left eyeball.
7. Remarkable distension of sella turcica.

Diagnosed clinically as: Chromophobe adenoma.

Tumour /

SERIAL NO. 2 (contd.)

Tumour partially removed by transphenoidal procedure on 15.2.26, and then given a course of deep X-ray therapy. Recurrence of symptoms on 14.2.30.

Histology: Cells: Transitional and eosinophiles. Stroma: Delicate and trabecular in parts; dense and hyaline in others. Multinucleated cells apparent. No mitosis. Monstrous nuclei visible. Colloid cysts.

SERIAL NO. 3.  
HOSP. NO. 55. (Mr Dott).  
R.C.P. NO. 7732/29, 5013/32, 5080/32.

MISS G.A. Examined on 12.6.1927.

Female, aged 10 9/12, school girl.

Past history: Nothing important.

C/O:

1. Lassitude - 1 year ago.
2. Headache for 7 months.
3. Dwarfism for 4 months.
4. Dimness of vision for 1 day.

Positive findings are:

1. Dyspituitarism.
2. Tender left eyeball.
3. Acuity of vision slightly diminished.
4. Bitemporal hemianopia.
5. Atrophic discs.
6. Enormous distension of sella turcica.

Clinical diagnosis: Chromophobe adenoma.

19.6.27: Operation - partial extirpation.

28.10.28: X-ray treatment.

New bone formation at the site necessitated a second operation on 3.9.29.

Recurrence. Operation repeated on 31.1.32.

Improved.

Histology: /

SERIAL NO. 3 (contd.)

Histology: Cells: Chief cells. Eosinophile cells with alpha granules are seen in some fragments stained specifically, ? normal.

Stroma of the specimen examined after second operation is hyaline and dense while the original biopsy is not.

SERIAL NO. 4.  
HOSP. NO. 80. (Mr Dott).  
R.C.P. NO. 4690/28.

MRS E.T.

Aged 30, married, 2 children, last pregnancy  
4 years ago.

Nothing to note in past history.

C/O:

1. Amenorrhoea 4 years.
2. Undue persistence of lactation after last pregnancy.
3. Adiposity 16 months ago.
4. Headache 11 months.
5. Lassitude for 11 months.
6. Deterioration of vision 7 months ago.

Examined on 9.1.28 with the following positive  
signs:

1. Dyspituitarism.
2. Total blindness of both eyes.
3. Bilateral primary optic atrophy.
4. Considerable enlargement and ballooning of sella turcica.

Diagnosis: Chromophobe adenoma.

Operation on 13.1.28 (transphenoidal approach;  
partial removal). Deep X-ray therapy..

Recovered and discharged on

Histology: /



SERIAL NO. 4 (contd.)

Histology: Chief cells in a diffuse trabecular pattern. Poor vascularity. Delicate stroma. No alpha granules on staining specifically (N.E.V.O.G.).

SERIAL NO. 5.  
HOSP. NO. 120. (Mr Dott).  
R.C.P. NO. 6410/28.

MRS C.B.

Examined on 6.10.28.

Female, aged 38, married, no children. Menes started at age of  $14\frac{1}{2}$  years and was regular.

Tuberculous cervical glands at the age of 13 - 17.

Ovariectomy and appendicectomy 5 years ago.

C/O:

1. Amenorrhoea for 7 years.
2. Sudden access of adiposity 7 years.
3. Attacks of faintness 6 years.
4. Attacks of epistaxis do.
5. Sudden decrease in sweating for 6 years.
6. Deterioration of vision  $4\frac{1}{2}$  years.
7. Headache for 4 years.
8. Diplopia (once encountered) 3 years ago.

Positive signs are:

1. Dyspituitarism.
2. Complete blindness of left eye.
3. Temporal hemianopias.
4. Left primary optic atrophy.
5. Globular expansion of sella turcica.

Clinically diagnosed as chromophobe adenoma.

Operated /

SERIAL NO. 5 (contd.)

Operated upon on 12.10.28 (partial removal transphenoidal). Then X-radiation.

Followed up till 1942 when she developed an attack of unconsciousness and of throbbing pain over the whole of the head.

Histology: Cells: Chief cells. Arrangement: Diffuse type. Vascularity: Not uniform all through. Colloid cysts.

SERIAL NO. 6.  
HOSP. NO. 137. (Mr Dott).  
R.C.P. NO. 7375/39.

G.A. Examined on 6.2.29.

Female, aged 55, single.

Symptoms started 10 years ago with lassitude.

Relative amenorrhoea that became complete at the age of 46. Right eye is totally blind for 6 years.

Patient has prominent features, heavy, well developed skeleton.

Progressive bitemporal fields defect.

Left eye only percepts light.

Bilateral primary optic atrophy.

Diplopia.

Partially extirpated on 6.3.29, then given a course of X-ray radiation.

Improved. Followed till 6.6.36, with improvement.

Histology: Cells: Chief. Arrangement: Sinusoidal. Stroma: Fibrous with hyaline degeneration. No mitosis, very little colloid.

SERIAL NO. 7.  
HOSP. NO. 141. (Mr Dott).  
R.C.P. NO. 7316/29. 7374/29.

MRS. R.

Female, aged 54.

History of hysterectomy for fibroids 25 years ago, otherwise nothing important found.

Glycosuria 9 months.

On examination: Left eye is blind with no light perception; right eye counts fingers at 8 feet.

Bilateral optic atrophy, rather incomplete on right side.

Diagnosis: Chromophobe adenoma.

Treatment: Operative (27.2.29) transphenoidal approach.

Histology: Cells: Chief, fetal cells. Pattern: Sinusoidal with tendency to papilliform arrangement. Pappillae becoming compact in parts. Stroma: Of fibrous tissue. Colloid degeneration in the tumour. Specific stain (N.E.V.O.G.) shows no granules in tumour.



SERIAL NO. 8.  
HOSP. NO. 148. (Mr Dott).  
R.C.P. NO. 7594/29.

MRS. S.

Female, 52 years old, married, menarche started late (at age of 19), has children in good health.

Nothing to note in previous history.

Examined on 2.4.29 with the following positive findings:

A. Subjective:

1. Amenorrhoea for 17 years (since last pregnancy).
2. Undue persistence of milk after weaning the child.
3. Attacks of headaches for 15 years.
4. Failure of vision for 13 years.
5. Lack of concentration.

B. Objective:

1. Blind left eye; right is 6/36.
2. Left complete primary optic atrophy.
3. Strabismus probably due to the blindness of the left eye.
4. Enormous enlargement of sella turcica on X-ray.

Diagnosed as chromophobe adenoma.

Treated by operation (transphenoidal approach - partial removal of tumour) on 10.4.29 and by X-radiation. Improved. Condition quiescent till 30.10.37.

Histology: Chief cells, diffuse pattern, no marked vascularity, scanty stroma, no mitosis.

SERIAL NO. 9.  
HOSP. NO. 173. (Mr Dott).  
R.C.P. NO. 8673/29.

V.C.O. (South Africa).

Male, aged 42, married for 16 years, but no family.

Apart from diphtheria, he had a motor cycle accident 7 years ago and an attack of sunstroke 5-6 years ago.

C/O:

1. Gradual loss of sexual desire for 6 years, now completely lost for 2-3 months.
2. Diminished perspiration 5 years ago.
3. Easily fatigued on exertion for 5 years.
4. Failure of vision for 8 months.

Examined on 4.9.29 with the following positive signs:

1. Dyspituitarism.
2. Diminished acuity of vision.
3. Bitemporal hemianopia.
4. Suggestion of atrophy in temporal margin.
5. Grossly enlarged sella turcica due to intrasellar tumour.

Diagnosed clinically as: Chromophobe adenoma.

On /

SERIAL NO. 9 (contd.)

On 14.9.29: Transphenoidal exposure, decompression and subtotal removal of adenoma.

X-ray treatment followed and patient is retaining satisfactory vision till 5.1.44.

Histology: Sheets of chief cells, sinusoidal pattern. No marked vascularity. Scanty supporting tissue. N.E.V.O.G. No alpha granules.

SERIAL NO. 10.  
HCSP. NO. 187. (Mr Dott).  
R.C.P. NO. 9055/29.

MRS. M.A.C.

Female, aged 31 years, married.

Ovario hysterectomy done 7 years ago for  
bleeding.

C/O:

1. Headaches for 3 years.
2. Deterioration of vision 1 year.

Examination revealed:

1. Almost complete left primary optic atrophy.
2. Wide left pupil with sluggish reflex.

Histology: Chief and transitional cells,  
sinusoidal arrangement in form of cords of cuboidal  
cells. Dense fibrous stroma partly hyalinised.  
Marked vascularity with haemorrhages. No mitosis.

SERIAL NO. 11.  
HOSP. NO. 211. (Mr Dott).  
R.C.P. NO. 9802/30.

J.H.

Male, 52 years old.

Nothing important to note in previous history.

Examined on January 1930 with the following

positive findings:

A. Subjective:

1. Headache for 3 months.
2. Deterioration of vision for 3 months.
3. Shooting pains 1 month.
4. Epistaxis from right nostril for 1 month.

B. Objective:

1. Moderate obesity.
2. Defective vision (left: 6/24).
3. Bitemporal hemianopia.

Operated upon on 2.2.30. Transphenoidal approach, fairly extensive tumour removal and sellar decompression. Recovered with improvement of vision.

Histology: <sup>0</sup>Fetal cells, perivascular arrangement, papillary pattern. Scanty hyaline stroma, moderate vascularity. No mitosis. No colloid. Necrotic changes evident.



SERIAL NO. 12.  
HOSP. NO. 213. (Mr Dott).  
R.C.P. NO. 9987/30.

A.W.

Female, aged 30 years.

Admitted C/O:

1. Amenorrhoea for  $2\frac{1}{2}$  years.
2. Acromegalic features (progressive)  $1\frac{1}{2}$  years.
3. Blurred vision for 6 weeks.

Examination revealed:

1. Moderate progressive acromegaly.
2. Bitemporal hemianopia.

Treated by operation on 23.2.30. Right trans-frontal procedure. Apparently complete removal of large pituitary adenoma.

Primarily recovered. Died 6 weeks after operation without ascertained cause of death.

Histology: Admixture of eosinophile cells (E.M.B. stain) and of transitional cells. Stroma delicate and hardly evident. Very vascular. Haemorrhage and necrosis visible.

SERIAL NO. 13.  
HOSP. NO. 271. (Mr Dott).  
R.C.P. NO. 1428/30.

L.B. (South Africa).

Male, aged 26, single.

Tonsillectomy done 12 years ago.

Admitted C/O: sexual desire and potency for

1. Gradual loss of sexual desire for 3 years.
2. Failure of vision recently.

Case diagnosed as chromophobe adenoma.

Operation done on 22.8.30.

Post operative death.

Histology: Chief cells, diffuse form.

Vascularity poor. Abundant fibrous tissue stroma  
with hyaline change.

Histology: Chief cells and transitional pro-  
cedinophilic cells. Sheets and cords of cells with  
tendency to arrange themselves around colloid material.  
Stroma of dense hyaline fibrous tissue. Vascularity  
is poor.

SERIAL NO. 14.  
HOSP. NO. 294. (Mr Dott).  
R.C.P. NO. 2176/30.

W.M.

Male, 64 years old.

Examined on 9.35 for:

1. Loss of sexual desire and potency for 20 years.
2. Deterioration of vision since 1916.

Examination revealed just a trace of mucus in

Histology: Chief cells and transitional pre-eosinophilic cells. Sheets and cords of cells with tendency to acinar formation around colloid material. Stroma of dense hyaline fibrous tissue. Vascularity is poor.

SERIAL NO. 15.  
HOSP. NO. 322. (Mr Dott).  
R.C.P. NO. 2398/31.

MISS E.B.

Female, aged 49, single.

History of concussion after a fall from a car,  
otherwise nothing important.

C/O:

1. Deterioration of vision 2 years.
2. Amenorrhoea 5 years.
3. Insomnia 2-3 years.
4. Attacks of headache 2-3 months.

Examination revealed just a trace of pallor in  
the fundi. Diagnosed as chromophobe adenoma.

Treated by transfrontal approach on 23.1.31.

Progressive recovery.

Histology: Cells: Chief. Pattern: Diffuse.

Stroma: Sparse trabeculae of delicate connective  
tissue. Vascularity: Poor. Specific stain  
(N.E.V.O.G.). No alpha granules.

SERIAL NO. 16.  
HOSP. NO. 366. (Mr Dott).  
R.C.P. NO. 3246/31.

I.T.

Female, aged 36. Stopped growing by the age of 17-18 years.

Examined on 20.5.31 with the following positive findings:

A. Subjective:

1. Increase in size of feet for 14 years.
2. Amenorrhoea for 9 years.
3. Recent attacks of headache.

B. Objective:

1. Right homonymous defect.
2. Some degree of pathological somnolence.

Diagnosed as eosinophil adenoma with considerable intra cranial protrusion of the growth.

Operated upon by transphenoidal procedure.

X-ray treatment followed.

Discharged and followed till 4.4.32 in a fairly good condition.

Histology: Chief cells and transitional cells with admixture of eosinophil cells (N.E.V.O.G. stain and E.M.B. stain). Stroma is delicate and scanty. Vascularity not marked. Colloid cysts visible.



SERIAL NO. 17.  
HOSP. NO. 390. (Mr Dott).  
R.C.P. NO. 3675/31 - 3849/31.  
N.P. NO. 846.  
P.M. NO. RIE/561/37.

J.G.

Male, aged 33 years.

Nothing to note in previous history apart from an influenzal attack 13 years ago.

C/O:

1. Enlargement of acral parts for 11 years.
2. Somnolence since then.
3. Increase in weight for 3 years.
4. Loss of memory for recent things since the attack of influenza.
5. Occasional headaches.

Examination revealed:

1. Acromegalic features.
2. Early bitemporal hemianopia.

A diagnosis of eosinophil adenoma was made.

Patient treated with deep X-ray therapy prior to operation.

Transphenoid decompression done in 1931. Biopsy removed. Condition improved for 4 years after.

Then he was readmitted for basal symptoms and died on 25.11.35 after operative procedure.

Histology: /

SERIAL NO. 17 (contd.)

Histology: Transitional and few eosinophil cells (E.M.B. stain). Sinusoidal pattern. Sheets of compact cells. Multinucleated cells apparent. Stroma dense. Colloid cysts visible. No marked vascularity.

P.M. revealed:

1. Radiation necrosis of temporal lobe.
2. Encysted empyema (right lung).
3. Emphysema.

No recurrence of pituitary tumour.

Examination reveals:

1. Hypopyclia.
2. Acuity of vision diminished (left: right 2/30; right: 8/30).
3. Right complete temporal hemianopia; left not altered.
4. Left primary optic atrophy and edema.
5. Considerable enlargement of sella turcica.

Diagnosis: Meningeal sarcoma or lymphoma.

Operated upon.

Histology:

SERIAL NO. 18.  
HOSP. NO. 402. (Mr Dott).  
R.C.P. NO. 3848/31 - 3882/31.

MISS A.C.

Female, aged 73, periods were regular, menopause at age of 50.

History of bilateral sciatica, earache, and phlebitis in right calf.

Admitted on 12.8.31.

C/O:

1. Gradual failure of vision for 6 months.
2. Occasional attacks of headache 5 months.
3. Somnolence 5 months.
4. Little perspiration in last year.

Examination reveals:

1. Hypopituitarism.
2. Acuity of vision diminished (left: light perception; right: 6/9).
3. Right complete temporal hemianopia.  
Left not charted.
4. Left primary optic atrophy and oedema superimposed.
5. Considerable enlargement of sella turcica.

Diagnosis: Pituitary adenoma or intra sellar craniopharyngioma.

Operated upon.

Histology: /

SERIAL NO. 18 (contd.)

Histology: Sheets of chief cells in sinusoidal form. Tendency to perivascular arrangement.

No mitosis. Scanty stroma. Vascularity poor.

- Admitted on 3.3.51.
- C/S:
1. Acute onset of illness with increased perspiration for three years.
  2. Headache for 2 years; vomiting and vertigo regular.
  3. Epistaxis on 3 occasions during last 12 years.
  4. Diabrotic hallucinations on several occasions.
  5. Blurring of vision for 6 months.
  6. Deafness and loss of libido 3 months.

Examination reveals:

1. Irregularly shaped.
2. Right relative anisometropia.
3. Slight loss of visual acuity on right side.
4. Slight upper quadrantic homonymous defect.
5. Absent right corneal reflex and slight hyperaesthesia of the right face.
6. Slight ballooning of the cells around of brain.

Diagnosis: Chromochloia adenoma.

Derivative

SERIAL NO. 19.  
HOSP. NO. 427. (Mr Dott).  
R.C.P. NO. 314/33 - 436/33.

W.R.S.

Male, aged 32, married, parents under size,  
has children.

Admitted on 9.9.31.

C/O:

1. Acral enlargement with increased perspiration for three years.
2. Headache for 3 years; vomiting and vertigo recently.
3. Epistaxis on 3 occasions during last  $1\frac{1}{2}$  years.
4. Olfactory hallucinations on several occasions.
5. Blurring of vision for 6 months.
6. Drowsiness and loss of libido 6 months.

Examination revealed:

1. Acromegalic features.
2. Right relative anosmia.
3. Slight loss of visual acuity on right side.
4. Right upper quadrantic homonymous defect.
5. Absent right corneal reflex and slight hypersthesia of the right face.
6. Slight ballooning of the sella turcica by X-ray.

Diagnosis: Chromophile adenoma.

Operative /



SERIAL NO. 19. (contd.)

Operative procedure on 19.11.33. After a course of antisyphilitic treatment because of a positive W.R. in blood. Primary recovery. Death of meningitis on 6.12.33.

Histology: Diffuse sheets of large transitional cells and eosinophile cells. Vasculature moderate. Delicate stroma. Colloid cysts. N.E.V.O.G. positive for alpha granules.

SERIAL NO. 20.  
HOSP. NO. 478. (Mr Dott).  
R.C.P. NO. 5221/32 - 5509/32.

W.G.M.

Male, aged 55, married.

Examined on 2.2.32 for difficulty of vision since 4 months and heaviness in head for 2 months. *positive*

*find* Patient is broadly built, obese, florid, plethoric. *60275*

Visual acuity diminished (left is 3/60). *11100*

Bitemporal hemianopia (with scotoma on left).

Left early primary optic atrophy.

X-ray appearances are those of a tumour growing primarily within the sella turcica.

Operation on 21.2.32. Right transfrontal radical extirpation of pituitary adenoma.

Died on 22.2.32 of circulatory failure.

Histology: Sheets of chief cells arranged in sinusoidal form. Little mitosis indicative of active growth. Vascularity is moderate. Stroma is delicate and trabecular. Colloid visible.

*Diagnosis: Chromophobe adenoma, intra-sellar craniopharyngioma.*

*Transfrontal radical extirpation of large adenoma done on 2.4.32, followed by X-ray treatment.*

*Improved /*

SERIAL NO. 21  
HOSP. NO. 489. (Mr Dott).  
R.C.P. NO. 5544/32 - 6010/32.

J.F.L.T.

Male, aged 32 years, married.

Adenoids removed at the age of 6 years.

Examined on 18.3.32, with the following positive findings:

Subjective:

1. Blurring and gradual failure of vision for 5 years.
2. Headache 4-5 years.
3. Lassitude since then.
4. Depression of sexual activity for 3-4 years.

Objective:

1. Diminished acuity of vision.
2. Bitemporal hemianopia.
3. Very early optic disc pallor on temporal half of left side.
4. Characteristic X-ray appearances of an expanding lesion originating within the sella turcica.

Diagnosis: Chromophobe adenoma, ? intra-sellar craniopharyngioma.

Transfrontal radical extirpation of large adenoma done on 3.4.32, followed by X-ray treatment.

Improved /



SERIAL NO. 21 (contd.)

Improved, no recurrence till 9.9.39.

Histology: Diffuse solid masses of chief cells.  
Marked vascularity (thin walled sinus-like vessels).  
Delicate stroma.

Inclusion of intermediate lobe remnants.

N.E.V.O.G. no alpha granules.

Examination reveals:

1. Mental impairment.
2. Bilateral primary optic atrophy.
3. Blind right eye, poor left eye.
4. Bitemporal hemianopia.
5. Immobility right pupil, sluggish reaction of left.
6. Quick nystagmus on looking to left.
7. Rigidity of legs, absent knee and ankle reflexes.
8. Decorticate posture.

Diagnosis: Supra sellar tumour (considerable extension into the base of the brain).

Operation on 19.8.38.

Death on 20.3.39.

Histology: /

SERIAL NO. 22.  
HOSP. NO. 508. (Mr Dott).  
R.C.P. NO. 5869/32 - 6009/32.

G.E.H.

Male, aged 62.

C/O:

1. Extravagant mismanagement of his affairs, poor judgment for 9 years.
2. Failure of vision for 6 years.

Examination reveals:

1. Mental impairment.
2. Bilateral primary optic atrophy.
3. Blind right eye, poor left eye.
4. Bitemporal hemianopia.
5. Immobile right pupil, sluggish reaction of left.
6. Quick nystagmus on looking to left.
7. Rigidity of legs, absent knee and ankle reflexes.
8. Incontinence.

Diagnosis: Supra sellar tumour (considerable extension into the base of the brain).

Operation on 19.5.32.

Death on 20.5.32.

Histology: /

SERIAL NO. 22 (contd.)

Histology: Cords and sheets of chief cells.

No marked vascularity (sinusoidal pattern).

No mitosis. Delicate stroma. Biopsy entangled fragments of brain substance. Few eosinophil cells are seen at periphery in remains of pituitary gland.

Objective findings are:

1. Hypophysitis.

2. Relative vascularity.

3. Marked bilateral primary optic atrophy with bilateral optic chiasmata and optic nerves.

4. Evident optic enlargement of the optic nerves.

Diagnosed clinically as: Pituitary adenoma.

Operation on 11/2/52 (right transfrontal approach,

disclosure and removal of large pituitary adenoma, drainage).

3101 /

SERIAL NO. 23.  
HOSP. NO. 523. (Mr Dott).  
R.C.P. NO. 6192/32 - 6552/32.  
P.M. NO. 369/32.

J.N.

Male, aged 37, married for 10 years but has no family. Nothing important to note in past history.

Examined on 28.6.32 for:

1. Gradual progressive bilateral failure of vision for 1 year.
2. Occasional slight frontal headache for 9 months.
3. Loss of libido for 6 months.
4. Intermittent lateral diplopia for 3 months.
5. Olfactory and gustatory hallucination for 3 months.

Objective findings are:

1. Hypopituitarism.
2. Relative right anosmia.
3. Marked bilateral primary optic atrophy with complete bitemporal hemianopia and low vision.
4. X-ray shows medium enlargement of the sella turcica.

Diagnosed clinically as: Pituitary adenoma.

Operation on 1.7.32 (right transfrontal approach, disclosure and radical removal of large pituitary adenoma, drainage).

Died /

SERIAL NO. 23 (contd.)

Died on 1.7.32 of circulatory failure.

Histology: Sheets and cords of chief cells arranged in a sinusoidal pattern. Tendency to acinar formation. Fetal cells with perivascular arrangement. Highly vascular. Scanty delicate stroma. Colloid cysts visible. Specific stains. No alpha granules.

P.M. examination reveals post operative haemorrhage.



SERIAL NO. 24.  
HOSP. NO. 329. (Mr Dott).  
R.C.P. NO. 6307/32 - 6551/32.

J.S:

Male, aged 57, married, has children.

History of deafness of right ear since the age of 25.

Examined on 7.7.32 for:

1. Dimness of vision for 14 months.
2. Painful and tender right eyeball for 1 year.
3. Abrupt loss of libido for 2½ years.

Objective positive findings are:

1. Bitemporal hemianopia.
2. Diminution of visual acuity.
3. Pale left disc with sharp margins and picture of choroiditis.
4. Deafness due to otosclerosis.
5. Globular enlargement of sella turcica consistent with intra sellar tumour.

Diagnosis: Chromophobe adenoma.

Operation on 13.7.32 (transfrontal radical extirpation of pituitary adenoma).

X-ray treatment followed. Discharged improved.

Histology: Sheets and cords of chief cells arranged /

SERIAL NO. 24 (contd.)

arranged in a sinusoidal pattern. Vascularity moderate. Stroma delicate. Little mitosis. Colloid visible.

Specific stain - no alpha granules.

Examined on 18.7.53. The following are the positive findings.

Subjective:

1. Gradual failure of vision, detected medically since the age of 11 years.
2. Rapid growth after the age of 13.
3. Attacks of headaches for the last 4 years.
4. Drowsiness for 2 years.
5. General weakness for 3 months.

Objective:

1. Acromegalic giant.
2. Poor visual vision in the left eye.
3. Bitemporal hemianopia.
4. Primary optic atrophy with oedema in the left eye.
5. Strabismus.
6. Nodular enlargement of thyroid.
7. Anemia.
8. X-ray appearances of moderate irregular enlargement.

Diagnosis /

SERIAL NO. 25.  
HOSP. NO. 533. (Mr Dott).  
R.C.P. NO. 6366/32. 6542/32.

J.H.S.

Male, 17½ years old, Jewish, Pole.

History of accident with trauma at age of 13.

Examined on 15.7.32. The following are the

positive findings:

Subjective:

1. Gradual failure of vision, detected medically since the age of 11 years.
2. Rapid growth after the age of 13.
3. Attacks of headache for the last 2 years.
4. Drowsiness for 2 years.
5. General weakness for 5 months.

Objective:

1. Acromegalic giant.
2. Poor visual vision in the left eye.
3. Bitemporal hemianopia.
4. Primary optic atrophy with oedema in the left side.
5. Strabismus.
6. Nodular enlargement of thyroid.
7. Asthenia.
8. X-ray appearances of moderate irregular enlargement.

Diagnosed /



SERIAL NO. 25 (contd.)

Diagnosed as oxyphil adenoma.

Operated upon on 20.7.32 (transfrontal procedure, extensive removal of very large adenoma, insertion of radium).

Patient died on 22.7.32 from oedema cerebri.

Histology: Transitional (pre-eosinophilic) cells, a fair number of eosinophiles with alpha granules (N.E.V.O.G. stain), few chief cells. Multinuclear forms detected. No mitosis. Stroma scanty. Vascularity poor.

SERIAL NO. 26.  
HOSP. NO. 549. (Mr Dott).  
R.C.P. NO. 6598/32 - 6682/32.

MRS E.R.

Female, aged 39, married and has two children.

Nothing important to note in the past history.

C/O:

1. Amenorrhoea for 2 years, complete  $1\frac{1}{2}$  years.
2. Failure of vision for 1 year.
3. Occasional epistaxis since 3 months.
4. Attacks of flushing.

Examined on 1.9.32 with the following positive findings:

1. Diminished acuity of vision (right: 6/60), (left: 6/12).
2. Bitemporal hemianopia.
3. Pallor of discs.
4. Definite and perfect globular enlargement of the sella turcica due to an intrasellar tumour.

Diagnosis: Chromophobe adenoma.

Operative treatment on 4.9.32 (transfrontal procedure, radical extirpation), followed by X-radiation.

Discharged home on 23.9.32.

Recurrence of symptoms on 3.2.38 (6 years later), with the development of myxoedema a year later.

Histology: /

SERIAL NO. 26 (contd.)

Histology: Chief and fetal cells, sinusoidal pattern, with sheets and cords of cells. No mitosis. Dense fibrous stroma. Vascularity poor.

2/01

1. Irregular periods 14 years ago, and amenorrhea for 12 years.
2. Amenorrhea features for 14 years.
3. Disturbance of vision 3-4 years.

Examined on 3.10.38, and the following positive findings were detected:

1. Ectopic, but typical adenomyosis.
2. Blood pressure 100/120, with moderate degree of cardiac hypertrophy.
3. Normal ophthalmoscopic appearance.

Diagnosed as uterine adenomyosis.

X-ray of spine.

Developed progressive bilateral hemianopia about a year later.

Operated on 11.2.38 (transphenoidal rather than laminectomy, partial removal of adenoma).

Improved and discharged on 3.7.38.

A later relapse on 4.5.40 (nearly 7 years later) with continued loss of memory.

Histology: /

SERIAL NO. 27.  
HOSP. NO. 554. (Mr Dott).  
R.C.P. NO. 8965/32 - 9302/32.

MISS E.S.

Female, aged 49 years, single.

C/O: Vascularity moderate. No

1. Irregular periods 14 years ago, and amenorrhoea for  $1\frac{1}{2}$  years.
2. Acromegalic features for 14 years.
3. Disturbances of vision 3-4 years.

Examined on 3.10.32, and the following positive findings were detected:

1. Moderate, but typical acromegaly.
2. Blood pressure 196/120, with moderate degree of cardiac hypertrophy.
3. Normal ophthalmoscopic appearances.

Diagnosed as eosinophil adenoma.

X-radiation done.

Developed progressive bitemporal hemianopia about a year later.

Operation on 21.6.33 (transphenoidal sellar decompression, partial removal of adenoma).

Improved and discharged on 5.7.33.

A late recurrence on 4.5.40 (nearly 7 years later) with confusion and loss of memory.

Histology: /

SERIAL NO. 27 (contd.)

Histology: Eosinophile cells in abundance with transitional cells (N.E.V.O.G. stain). Sinusoidal pattern. Scanty delicate trabecular stroma with early hyalinisation. Vascularity moderate. No mitosis.

P.M. revealed arteriosclerosis of internal carotids.

Weight 4 years.

1 year.

1 year.

6 months.

in respiration.

revealed:

1. Encephalic features,

2. Meningeal reaction.

3. Encephalic features in right and left hemispheres.

4. Meningeal reaction.

5. Encephalic features in skull bones with extension to paranasal sinuses.

6. Encephalic features (radial extension of pituitary gland) (or anteriorly).

7. Meningeal reaction.

8. Primary process, died on 11.3.33.

Histology:



SERIAL NO. 28.  
HOSP. NO. 581. (Mr Dott).  
R.C.P. NO. 7402/33, 7613/33.

J.G.

Male, 35 years old, rubber worker.

History of malaria since 16 years.

C/O:

1. Enlargement of acral parts for 1 year.
2. Increase in weight for 4 years.
3. Somnolence  $1\frac{1}{2}$  years.
4. Polyuria for 1 year.
5. Lassitude for 6 months.
6. Recent increase in perspiration.

Examination on 29.11.32 revealed:

1. Acromegalic features.
2. Diminished visual acuity.
3. Sloping upper temporal quadrants and right central scotoma.
4. Fairly normal discs.
5. General thickening of skull bones with irregular ballooning of sella turcica.

Operation on 4.1.33 (radical extirpation of pituitary adenoma for acromegaly).

X-radiation followed.

Primary recovery, died on 11.2.33.

Histology: /

SERIAL NO. 28 (contd.)

Histology: Diffuse cellularity. Transitional cells in abundance and a fair number of eosinophiles, (N.E.V.O.G. stain). Extra cellular granules. Scanty stroma. No marked vascularity.

P.M.: 1. Nodule of tumour between lateral wall of sella and cavernous sinus.

2. Emaciation.

3. Gastrointestinal atrophy.

4. Pituitary degeneration for 5 weeks.

5. Diabetes for 5 weeks.

6. Vertical deviation.

7. Attacks of nausea, but no vomiting.

8. History of tumor.

9. Hypoparathyroidism.

10. Reduced acuity of vision (right 8/60; left 20/20 - hard bilateral periorbital).

11. Bilateral ptosis.

12. Mild left optic atrophy.

13. Single positive reaction.

14. Birth 1907.

Diagnosis of pituitary tumor due to pituitary

adenoma. 1. to hypophyseal-stalk or Rathke's pouch type was made.

Operation.

SERIAL NO. 29.  
HOSP. NO. 582. (Mr Dott).  
R.C.P. NO. 7240/32.  
N.P. NO. 1824.  
P.M. NO. RIE/428/41.

J.A.

Female, aged  $17\frac{1}{2}$  years, no menses yet.

Admitted on 28.11.32.

C/O:

1. Little or no growth after age of 14 years.
2. Obesity for  $2\frac{1}{2}$  years.
3. Visual deterioration for 5 weeks.
4. Headache for 3 weeks.
5. Partial deafness.
6. Attacks of nausea, but no vomiting.

Examination reveals:

1. Hypopituitarism.
2. Reduced acuity of vision (right: 6/60;  
left: hand movements perception).
3. Bitemporal hemianopia.
4. Pale atrophic left fundus.
5. Sluggish pupillary reaction.
6. Brisk knee jerks.

Diagnosis of chiasmal lesion due to pituitary adenoma or to hypophyseal-stalk or Rathke's pouch cyst was made.

Operation /



SERIAL NO. 29 (contd.)

Operation on 7.12.32. Transfrontal procedure.

X-radiation.

Recovered from operation.

Episodes of cerebral symptoms either due to aneurysm or haemorrhage in connection with tumour remains. Died on 8.11.41. (About 9 years after operation).

Histology: Chief cells, diffuse pattern, poor by vascular, stroma densely fibrosed and hyalinised.

P.M.: Death due to intracerebral haemorrhage.

SERIAL NO. 30.  
HOSP. NO. 613. (Mr Dott).  
R.C.P. NO. 7676/33, 7846/33.

G.E.

Male, aged 30 years, married for 7 years, has one child (4 years old).

Previous history: Nothing to note.

C/O: Headache and deterioration of vision for 22 months.

Examined on 9.2.33 and the following positive signs were noticeable:

1. Diminished acuity of vision.
2. Perimetry shows evidence of pressure on chiasma.
3. Slight pallor of left fundus.
4. Grossly enlarged sella turcica.

Diagnosed as slowly growing adenoma or cranio-pharyngeal cyst.

Operation on 12.2.33. Radical extirpation of pituitary chromophobe adenoma.

Died on 14.2.33 due to formation of post operative clot. Cerebral oedema, subarachnoid blockage.

Histology: Diffuse arrangement, chief cells, delicate trabecular stroma, no marked vascularity. Specific stain (N.E.V.O.G.), no alpha granules.

SERIAL NO. 31.  
HOSP. NO. 665. (Mr Dott).  
R.C.P. NO. 9075/33, 9301/33.

MRS. N. (South Africa).

Aged 41, married, has a daughter.

Nothing to note in previous illnesses.

C/O:

1. Progressive acromegalic features 12-14 years.
2. Irregular menstruation for 10 years and complete amenorrhoea for 1 year.
3. Lack of energy for 10 years.
4. Deterioration of vision for 1 year.
5. Headache for 6 years.

Examination on 27.6.33 revealed:

1. Typical acromegalic features.
2. Very early bitemporal hemianopia.
3. Moderate but very definite globular distension of the sella turcica.

Operation on 1.7.33. Transphenoidal sellar decompression. Presumed partial extirpation of adenoma. Insertion of radium tubes.

Died on 5.7.33.

Histology: Transitional and eosinophile cells in considerable number, (N.E.V.O.G. stain). Delicate meshwork of connective tissue. Vasculature moderate.

SERIAL NO. 32.  
HOSP. NO. 668. (Mr Dott).  
R.C.P. NO. 9413/33, 9601/33.

MRS J.B.

Aged 64 years, married, has 9 of a family.

Cholecystectomy in 1917, miscarriage at age of 41.

History of two car-accidents within the last 4 years, but with no ill effects.

C/O:

1. Amenorrhoea since the age of 42.
2. Failure of vision for 5 years.
3. Occasional diplopia.
4. Asthenia recently.

Examination on 28.7.33 revealed:

1. Diminished visual acuity (right: 6/18; left: 6/24).
2. Clean cut bitemporal hemianopia.
3. Pale discs suggestive of a not yet obvious primary optic atrophy.
4. Definite enlargement of sella turcica.

Diagnosed as slowly growing pituitary adenoma.

Operation on 2.8.33. Right transfrontal radical extirpation.

Died on 3.8.33 with apparently cardiac failure.

Histology: Chief and fetal cells. Sinusoidal and papillary perivascular patterns. Delicate stroma. No mitosis. No alpha granules (N.E.V.O.G. stain).



SERIAL NO. 33.  
HOSP. NO. 675. (Mr Dott).  
R.C.P. NO. 9546/33, 9867/33.

MRS R.

Aged 53 years.

History of epileptiform attacks and of tuberculous cervical lymphadenitis when young.

C/O:

1. Cessation of menstruation at age of 45.
2. Gradual failure of vision for 19 months.

Examined on 3.8.33 and the following positive signs were noticed:

1. Slight cardiac hypertrophy. B.P. 184/110.
2. Diminished visual acuity (right counts fingers, left reads  $\frac{1}{2}$  inch print with difficulty).
3. Bitemporal hemianopia.
4. Slight pallor of fundi but within normal limits.
5. X-ray appearances of intra sellar tumour enlarging upwards.

Diagnosis: Chromophobe adenoma.

Operation on 16.8.33. Radical extirpation of adenoma. Right transfrontal procedure.

Histology: Chief cells in sheets. Sinusoidal pattern. Hyaline stroma. Highly vascular.

SERIAL NO. 34.  
HOSP. NO. 686. (Mr Dott).  
R.C.P. NO. 9897/33.

W.A.

Male, aged 53 years, married.

Congenitally myope with strabismus.

Admitted on 2.9.33.

C/O:

1. Epileptic seizure dating to 7 years ago.
2. Polyuria and polydipsia for 2 years.
3. Deterioration of vision in the last 5 months.

Examination revealed:

1. Dyspituitarism.
2. Congenitally defective right eye,  
divergent strabismus (old standing).
3. Bitemporal hemianopia. Right eye central  
scotoma.
4. Marked degree of bilateral primary optic  
atrophy.
5. Sella turcica slightly enlarged and  
deepened.

Diagnosis as: Supra sellar lesion ? meningioma,  
? adenoma, or ? craniopharyngioma.

Operation on 6.10.33. Partial extirpation.

Died on 19.10.33.

Histology: /

SERIAL NO. 34. (contd.)

Histology: Sheets of chief cells. Sinusoidal arrangement. Densely fibrosed stroma with hyaline degeneration. Specific stains show no alpha granules. Vascularity is marked. Areas of haemorrhage (fresh and old).

1. Onset of symptoms 10 months ago.

2. Rapid increase in weight 1 year.

3. Enlargement of breasts with presence of milk 1 year.

4. Gradual progressive deterioration of vision 6 months.

The following positive findings were noticed:

1. Hypertension.

2. Bilateral exophthalmos.

3. Right optic chiasm as compared with left.

4. Poor appearance of intra ocular tumour.

Diagnosis: Prolactinoma.

Operated on 10.10.33. Medical supervision of optic chiasm.

Post-operative course.

Discharge 11.10.33.

Diagnosis: Recurrence on 27.8.33. Operated

upon on 12.8.33. (Radical intra capsular excision)

of recurrent tumour.

Histology:

SERIAL NO. 35.  
HOSP. NO. 702. (Mr Dott).  
R.C.P. NO. 6/33, 127/33.

MRS C.M.

Aged 32, widow.

History of left cervical rib 7 years ago.

Examined on 11.10.33 for:

1. Abrupt amenorrhoea 16 months ago.
2. Rapid increase in weight 1 year.
3. Enlargement of breasts with presence of milk, 1 year.
4. Gradual progressive deterioration of vision 6 months.

The following positive findings were noticed:

1. Dyspituitarism.
2. Bitemporal hemianopia.
3. Slight pallor of left disc as compared with right.
4. X-ray appearances of intra sellar tumour.

Diagnosed as chromophobe adenoma.

Operation on 18.10.33. Radical extirpation of cystic adenoma.

Deep X-ray treatment.

Discharged. Recurrence on 27.8.38. Operated upon on 14.9.38. (Radical intra capsular extirpation of recurrent adenoma).

Histology: /



SERIAL NO. 35 (contd.)

Histology: Sections available are those taken after the first operation.

Cords and sheets of chief cells. Sinusoidal pattern. Fetal cells with perivascular arrangements. Hyaline fibrous stroma. Vascularity poor. Aggregations of lymphocytes. N.E.V.O.G. stain reveals same cells containing alpha granules.

3. Dilated nasal cavity (detected by medical exam) 2 months ago.

The following positive findings were noticed:

1. Nasal cavity: Right 3/8; left acuity flags at 2 metres.

2. Bilateral hemianopia, complete in the left eye with central scotoma.

3. Failure of left knee.

4. Diplopia on reading only.

5. Many deep and rounded cells packed with mitotic figures in the wall of the tumour.

Diagnosis: Ependymoid tumour.

Operation: 7.8.34. Radical extirpation of

pituitary tumour.

Died on 7.11.34 from rapid circulatory failure.

Histology: Diffuse pattern. Chief cells.

Partial replacement of stroma. Abundant lymphocytic

aggregations. No marked vascularity. Parts of the

pituitary /

SERIAL NO. 36.  
HOSP. NO. 753. (Mr Dott).  
R.C.P. NO. 1225/34, 1401/34.

W.C.

Male, aged 35 years, single, never experienced sexual desire, nor has any manifest of sexual activity.

Examined on 1.3.34 for:

1. Attacks of headache for 1 year.
2. Occasional diplopia 3 months ago.
3. Diminished visual acuity (detected by medical exam) 2 months ago.

The following positive findings were noticed:

1. Visual acuity: Right: 6/9; left counts fingers at 2 metres.
2. Bitemporal hemianopia, complete in the left eye with central scotoma.
3. Pallor of left disc.
4. Diplopia on reading only.
5. Fairly deep and rounded sella turcica with calcification in the wall of the tumour.

Diagnosed as: Epidermoid tumour.

Operation: 7.3.34. Radical extirpation of pituitary adenoma.

Died on 9.3.34 from rapid circulatory failure.

Histology: Diffuse pattern. Chief cells.

Partial hyalinosis of stroma. Abundant lymphocytic aggregations. No marked vascularity. Parts of the pituitary /

SERIAL NO. 36 (contd.)

pituitary gland seen with lymphocytic infiltrations and with vesicles containing colloid in the pars intermedia.

Case, aged 45 years, single.

Nothing important to note in past history.

Examination on 10.4.34 revealed the following

positive findings:

Subjective:

1. Gradual failure of vision for the last 4 years.
2. Diplopia for 2 1/2 years.

Objective:

1. Moderate pallor of right optic disc.
2. Right temporal hemianopia with a small central scotoma.
3. Binocular visual acuity on right side (1/30 corrected).
4. Appearance as if the sella turcica extended down into the body of the sphenoid.

Diagnosis: Extensive intra-sellar tumour.

Operation: 26.4.34. Radical extirpation of

pituitary chromophobe adenoma (transfrontal).

Died on 27.4.34 from cerebral oedema.

Histology: /

SERIAL NO. 37.  
HOSP. NO. 774. (Mr Dott).  
R.C.P. NO. 1684/34, 1856/34.  
P.M. NO. RIE/241/34.

D.H.

Male, aged 45 years, single.

Nothing important to note in past history.

Examination on 10.4.34 revealed the following  
positive findings:

Subjective:

1. Gradual failure of vision for the last 4 years.
2. Diplopia for  $2\frac{1}{2}$  years.

Objective:

1. Moderate pallor of right optic disc.
2. Right temporal hemianopia with a small central scotoma.
3. Diminished visual acuity on right side (4/60 corrected).
4. Appearances as if the sella turcica extended down into the body of the sphenoid.

Diagnosis: Extensive intra sellar tumour.

Operation: 25.4.34. Radical extirpation of  
pituitary chromophobe adenoma (transfrontal).

Died on 29.4.34 from cerebral oedema.

Histology: /

SERIAL NO. 37 (contd.)

Histology: Chief cells in sheets with sinusoidal pattern. Fetal cells with perivascular palisade arrangement. Partial hyalinosis of stroma. Colloid vesicles in tumour mass. Vascularity moderate. Specific stains show no alpha granules. Lymphocytic aggregations are seen in some parts.



SERIAL NO. 38.  
HOSP. NO. 777. (Mr Dott).  
R.C.P. NO. 1846/34.

D.A.G. (Australia).

Male, aged 49, married, and girl 15 years old.

History of sudden increase in weight 21 years ago,  
but patient reduced himself by dieting.

Examined on 1.5.34 for:

1. Gradual loss of vision in the left eye since 5 years; almost blind for the last 3 years.
2. Defective field of vision for 6 months.

The following positive signs were noted:

1. Dyspituitarism (obesity, soft atrophic skin).
2. Progressive temporal hemianopia in right eye, and a small patch of light perception remains in the upper nasal quadrant in left eye.
3. Marked degree of primary optic atrophy on left side.
4. Extensive globular expansion of the sella turcica.

Diagnosed as: Slowly growing intra sellar chromophobe adenoma.

Operation on 13.5.34. Radical extirpation of chromophobe adenoma (left transfrontal procedure).

Died on 22.5.34 with circulatory failure.

Histology: /



SERIAL NO. 38 (contd.)

Histology: Cords and sheets of chief cells. Sinusoidal arrangement. Fetal cells with the perivascular papillary pattern. Compact papillae in some parts. Scarce mitotic figures. Vasculature marked. No alpha granules seen with specific stain.

Examination on 30.5.34 revealed the following

Positive findings:

1. Ataxia

1. Attacks of headache for 16 months.
2. Irregular menstruation for 8 years and absolute amenorrhoea in the last 3 months.
3. Loss of vision 6 months ago.
4. Numbness of right chest side few days ago.
5. Unsteadiness in posture and gait 3-4 weeks.

Negative:

1. Loss of concentration.
2. Parosmia.
3. Right eye is blind, left eye counts fingers at 2 metres.
4. Temporal field defect in left eye.
5. Consensual pupillary reaction on both sides, left pupil somewhat dilated than the right.

1.

SERIAL NO. 39.  
HOSP. NO. 796. (Mr Dott).  
R.C.P. NO. 2161/34, 2346/34, 2467/34.

MRS A.M.

Aged 41 years.

Nothing of importance to note in previous illnesses.

Examination on 30.5.34 revealed the following positive findings:

Subjective:

1. Attacks of headache for 16 months.
2. Irregular menstruation for 2 years and absolute amenorrhoea in the last 5 months.
3. Loss of vision 6 months ago.
4. Parasthesia of right ulnar side few days ago.
5. Unsteadiness in posture and gait 2-3 weeks.

Objective:

1. Loss of concentration.
2. Parosmia.
3. Right eye is blind, left eye counts fingers at 2 metres.
4. Temporal field defect in left eye.
5. Consensual pupillary reaction on both sides, left pupil somewhat dilated than the right.
6. /

SERIAL NO. 39 (contd.)

6. X-ray shows extensive gap in the base of the skull including the floor of the sella and base sphenoid (suggestive of malignant invasion of the base).

Diagnosis: Pharyngeal endothelioma.

Treated by deep X-radiation. Operation followed on 6.7.34 (transphenoidal sellar decompression, insertion of radium tubes into tumour). Improved.

Histology: Chief cells. Sinusoidal pattern. Fetal cells with perivascular arrangement. Stroma no marked fibrosis or hyalinosis. Areas of necrosis detected. Few mitotic figures. Vascularity moderate.

SERIAL NO. 40.  
HOSP. NO. 803. (Mr Dott).  
R.C.P. NO. 2339/34 - 2468/34.

F.B. (South Africa).

Male, aged 47 years, married, has 2 children.

Past history: Gun shot wound in chest with the development of pneumonia, War 1914. Appendicectomy 6 years ago, submaxillary lipoma removed 18 months ago.

Examination on 4.7.34 reveals:

Subjective:

1. Gradual deterioration of vision for 18 months with rapid failure in the last two months.
2. Diplopia for 18 months.

Objective:

1. Visual acuity: Right: 6/36; left: 6/36.
2. Bitemporal hemianopia.
3. Questionable very slight pallor of the discs.
4. Moderate enlargement of sella turcica on X-ray.

Diagnosis: Chromophobe adenoma.

Treated by operation on 8.7.34 (right transfrontal extirpation of the tumour).

Primary recovery.

Died /

SERIAL NO. 40 (contd.)

Died later of mental, physical and dysenteric symptoms. (South Africa).

Histology: Cords and sheets of chief cells. Sinusoidal pattern. Hyaline fibrous stroma. Vascularity marked with haemorrhage. Cysts containing colloid substance.

1. Exophthalmos 18 months ago.
2. Failure of vision with squint 6 months ago.
3. Slowness of mentality for 18 months.
4. Epistaxis 6 months ago.

Positive findings are:

1. Exophthalmos.
2. Slow mentality, suggestion of left frontal excitation.
3. Left exophthalmos with lideminent eyelids.
4. Photophobia in the left eye.
5. Temporal hemianopia.
6. Fall of fundi especially the left.
7. Partial left third nerve paresis.
8. Sella turcica enormously enlarged.

Diagnosed as: Encephalocystoma (long standing - broke sideways).

Operation /



SERIAL NO. 41.  
HOSP. NO. 809. (Mr Dott).  
R.C.P. NO. 2415/34, 2469/34.

B.B.B. (South Africa).

Male, aged 38, previous history of malaria  
18 years ago.

Examined on 11.7.34 for:

1. Epileptic attacks with headaches before and  
and after since 1919.
2. Exophthalmos 18 months ago.
3. Failure of vision with squint 6 months ago.
4. Slowness of mentality for 18 months.
5. Aphasia 2 months ago.

Positive findings are:

1. Dyspituitarism.
2. Slow mentality, suggestion of left frontal  
complication.
3. Left exophthalmos with oedematous eyelids.
4. Photophobia in the left eye.
5. Temporal hemianopia.
6. Pallor of fundi especially the left.
7. Partial left third nerve paresis.
8. Sella turcica enormously enlarged.

Diagnosed as: Chromophobe adenoma (long standing  
- broke sideways).

Operation /



SERIAL NO. 41 (contd.)

Operation on 18.7.34. Disclosure of laterally placed nodule of pituitary adenoma in left middle fossa. Intracapsular removal. On 5.9.34 transphenoidal sellar decompression and also right transfrontal. No tumour in the sella turcica. It may be that some natural process haemorrhagic or necrosis has cleared the original sellar tumour. Deep X-radiation followed. Recovered for 1 year.

Discharged improved on 13.10.34.

Histology: Chief cells. Sinusoidal pattern. Marked vascularity. Stroma delicate and scanty. No mitosis. Presumably early adenoma.

1. Diminished vision in left eye.

2. Exophthalmos.

3. Very slight pallor of the left disc.

4. Long appearance of small intrasellar cyst.

Diagnosed as long standing adenoma.

Treated with deep X-radiation, before and after operation.

Operation on 18.9.34. Transphenoidal sellar

decompression. Partial removal of adenoma.

Recovered and followed 5 years after.

Histology:

SERIAL NO. 42.  
HOSP. NO. 824. (Mr Dott).  
R.C.P. NO. 2871/34.

MISS F.H.

Aged 27 years, school-teacher.

Tonsillectomy done to her.

C/O:

1. Enlargement of acral parts 8 years ago.
2. Headache 6 years ago.
3. Amenorrhoea for 1 year.
4. Increase in weight recently.

Examined on 11.8.34 and the following positive findings noted:

1. Moderately early acromegaly.
2. Diminished vision in left eye.
3. Temporal hemianopia.
4. Very slight pallor of the left disc.
5. X-ray appearances of small intra sellar expansion.

Diagnosed as long standing eosinophil adenoma.

Treated with deep X-radiation, before and after operation.

Operation on 19.9.34. Transphenoidal sellar decompression. Partial removal of adenoma.

Recovered and followed 5 years after.

Histology: /

SERIAL NO. 42 (contd.)

HOSP. NO. 500, (1st Dept.),  
I.O.P. NO. 200/34.

Histology: Transitional cells, diffuse pattern.  
Scanty stroma, marked vascularity. Eosinophil cells  
detected in abundance with the specific stain  
(N.E.V.O.G.). Necrosis of cells visible.

Examined on 24.9.34 for:

1. Generalized headache 4 years.
2. Deterioration of vision of right eye  
7 months ago.
3. Sudden onset of blindness 3 months ago.
4. Past history of epilepsy and polydipsia.

Physical findings:

1. Loss of vision confined to lower  
temporal field of right eye.
2. Slight anterior chamber reaction with  
a slight depression of the remaining  
upper temporal field. Left field shows  
a relative nasal hemianopia.
3. Slightly advanced right primary optic atrophy.
4. Slight enlargement of sella turcica.

Diagnosis: Intracellar pituitary tumour

causing a relative optic atrophy.

Operation on 3.10.34. Extirpation of pituitary

tumour. Recovery.

Recovery and discharged.

Histology: Chief cells, diffuse pattern. Marked  
vasculature. Stroma scanty and trabecular. No  
mitoses. Colloid cysts visible.

SERIAL NO. 43.  
HOSP. NO. 860. (Mr Dott).  
R.C.P. NO. 3001/34.

A.B. (India).

Male, aged 13½, single.

History of fall from cot when child.

Examined on 24.9.34 for:

1. Generalised headaches 4 years.
2. Deterioration of vision of right eye 9 months ago.
3. Sudden access of adiposity 6 months ago.
4. Doubtful history of polyuria and polydipsia.

Positive findings are:

1. Acuity of vision diminished to hand movement on right side.
2. Curious interior altitudinal hemianopia with a greater depression of the remaining upper temporal quadrant. Left field shows a relative nasal hemianopia.
3. Fairly advanced right primary optic atrophy.
4. Enormous enlargement of sella turcica.

Diagnosis: Intra sellar pituitary tumour enlarging to implicate optic fibres.

Operation on 3.10.34. Extirpation of pituitary tumour. X-radiation.

Recovered and discharged.

Histology: Chief cells, diffuse pattern. Marked vascularity. Stroma scanty and trabecular. No mitosis. Colloid cysts visible.

SERIAL NO. 44. (contd.)

Operation on 6.3.35. Radical extirpation of pituitary chromophobe adenoma involving section of defective right optic nerve.

Patient died on 8.3.35.

Histology: Sheets of chief cells, hyperchromatic nuclei. No mitosis. Sinusoidal arrangement. Marked vascularity with fresh and old haemorrhages. Necrosis and perivascular lymphocytic aggregations. Stroma scanty. (E.P.B. stain - no chromophile granules).

1. Hypertelorism.
2. Hip rickets - kyphoscoliosis.
3. Chronic pulmonary type of fingers.
4. Visual acuity: left able to read type script with difficulty; right light perception.
5. Fields: Binasal hemianopsia.
6. Vision: Right advanced primary optic atrophy.
7. Extensive destruction of the sella turcica and hypophyseal stalk calcification.

Diagnosis: Chromophobe adenoma.

Operation on 6.4.35. Partial extirpation of chromophobe pituitary adenoma (transfrontal procedure) followed by dose X-ray therapy.

Discharged /



SERIAL NO. 45.  
HOSP. NO. 936. (Mr Dott).  
R.C.P. NO. 4815/35.

MISS L.P.

Aged 38 years; past history of chest troubles.

C/O:

1. Amenorrhoea 6 years ago.
2. Failure of vision 2 months ago.
3. Fatigue during past year.
4. Slight increase in weight for 1 year.
5. Dull ache at back of neck recently.

Examination on 2.4.35 revealed:

1. Dyspituitarism.
2. Old rickets - kyphoscoliosis.
3. Chronic pulmonary type of fingers.
4. Visual acuity: Left able to read type script with difficulty; right light perception.
5. Fields: Bitemporal hemianopia.
6. Fundi: Right advanced primary optic atrophy.
7. Extensive destruction of the sella turcica and ? supra sellar calcification.

Diagnosis: Chromophobe adenoma.

Operation on 6.4.35. Partial extirpation of chromophobe pituitary adenoma (transfrontal procedure), followed by deep X-ray therapy.

Discharged /



SERIAL NO. 45 (contd.)

Discharged home on 11.5.35.

Histology: Chief cells. Diffuse pattern.

Little or no mitosis. Colloid formation.

Vascularity not marked. Stroma scanty.

1. Adenoma of the thyroid gland.

2. Impairment of vision with diplopia.

Admitted on 11.5.35 and the following positive

1. Impairment of vision.

2. Impaired visual acuity.

3. Bilateral homonymous hemianopia.

4. Low degree of atrophy in fundi.

5. Bilateral expansion of the sella turcica with  
marked short backward-tilted dorsum sellae  
and well seen hammer-like floor.

6. Adenoma of slowly growing chromophobe adenoma.

Operation on 11.5.35. Intra-ocular extirpation

of adenoma (transfrontal procedure).

Discharged on 11.5.35.

Histology: Chief cells. Sinusoidal

type. Vascularity marked. Stroma dense and hyaline

in parts, especially marked perivascular hyalinosis.

No mitoses. No lipid granules (N.E.V.O.G. stain).

SERIAL NO. 46.  
HOSP. NO. 966. (Mr Dott).  
R.C.P. NO. 5756/35, 5921/35.

MISS E.T.W. (South Africa).

Aged 49 years, menes started at age of 14-15.

C/O:

1. Amenorrhoea for 24 years.
2. Deterioration of vision with diplopia  
4 years ago.

Examined on 28.5.35 and the following positive signs were noted:

1. Dyspituitarism.
2. Diminished visual acuity.
3. Bitemporal hemianopia.
4. Some degree of atrophy in fundi.
5. Notable expansion of the sella turcica with  
a thin short backward-tilted dorsum sellae  
and wide open saucer-like floor.

Diagnosed as slowly growing chromophobe adenoma.

Operation on 5.7.35. Intra capsular extirpation  
of pituitary adenoma (transfrontal procedure).

Discharged on 23.7.35.

Histology: Sheets of chief cells. Sinusoidal  
type. Vascularity marked. Stroma dense and hyaline  
in parts, especially marked perivascular hyalinosis.  
No mitosis. No alpha granules (N.E.V.O.G. stain).

SERIAL NO. 47.  
HOSP. NO. 995. (Mr Dott).  
R.C.P. NO. 6034/35.

R.B.

Male, 59 years, married, has children.

Nothing important to note in past history.

C/O:

1. Attacks of giddiness 4 years ago.
2. Deafness of both ears.
3. Shooting pains over right eye 1 year ago, disappeared and returned 4 months ago.
4. Deterioration of vision 1 year.

Examination on 13.7.35 revealed:

1. Lack of concentration.
2. Light perception in the right eye and hand movements at 10 inches. Left: 6/24.
3. Temporal hemianopia left eye.
4. ? Slight right lower facial weakness.
5. Slight middle ear deafness on left side.
6. Absence of sexual activity for the last 6 years.
7. Hypochromic, microcytic anaemia, leucocytosis.
8. X-ray appearances of intrasellar tumour.

Diagnosis: Pituitary chromophobe adenoma.

Operation on 13.8.35 right transfrontal intracapsular extirpation of chromophobe adenoma.

Discharged /

SERIAL NO. 47 (contd.)

Discharged, improved, on 28.8.35.

Histology: Cords and sheets of chief cells.

Sinusoidal pattern. Areas of old haemorrhage.

Stroma shows marked hyalinosis.

3/0:

1. Onset insidious during past 3-5 years.
2. Progressive rapidly increasing obesity for 3 years.

Examination on 20.7.35 revealed:

1. Dysmetria: (Obesity - limbs - gait).
2. Left vision hand movements.
3. Bilateral homonymous - asymmetrical.
4. No definite optic atrophy.
5. Left eye a rather small, rounded type of globe.

Diagnosis: Hypophyseal adenoma enlarging in an irregular manner.

Operation: Radical extirpation supra-sellar transphenoidal procedure, on 28.8.35.

Since on 28.8.35 pt. circulatory failure, hypotensive disturbance and massive cerebral oedema.

Histology /

SERIAL NO. 48.  
HOSP. NO. 1010. (Mr Dott).  
R.C.P. NO. 6192/35, 6298/35.  
N.P. NO. 281.  
P.M. NO. RIE/476/35.

J.H.

Male, aged 23 years, single, book-keeper.

Did not shave till the age of 19 and only shaves on alternate days.

C/O:

1. Ocular discomfort during past 4-5 years.
2. Progressive rapidly increasing adiposity for 3 years.

Examination on 20.7.35 revealed:

1. Dyspituitarism. (Obesity - hair - gonads).
2. Left vision hand movements.
3. Bitemporal hemianopia - asymmetrical.
4. No definite optic atrophy.
5. X-ray shows a rather small, rounded type of sella turcica.

Diagnosis: Chromophobe adenoma enlarging in an irregular manner.

Operation: Radical extirpation supra sellar chromophobe pituitary adenoma. Left transfrontal procedure, on 22.8.35.

Died on 23.8.35 of circulatory failure, hypothalamic disturbance and massive cerebral oedema.

Histology: /



SERIAL NO. 49.  
HOSP. NO. 1188. (Mr Dott).  
R.C.P. NO. 9793/36, 9887/36.

MRS A.K.

Aged 57 years, married, has 2 of a family.

Nothing important to note in the past history.

C/O:

1. Cessation of menstruation for 8 years.
2. Parasthesia in head.
3. Rapid increase in weight for 1 year.
4. Slight increase of perspiration.
5. Insomnia for 3 months.

Examination on 26.6.36 revealed:

1. Patient is tall and stout.
2. Visual acuity diminished.
3. Papilloedema on both sides, more marked on left.
4. Defective fields of vision with scotoma.
5. Sluggish pupillary reaction to light.
6. X-ray shows an enormous flat excavation of the sella, due to an extensive old standing adenoma.

Diagnosis: Pituitary adenoma.

Operation on 12.8.36. Radical extirpation of chromophobe adenoma (right transfrontal route).

Discharged /



SERIAL NO. 49 (contd.)

Discharged to a convalescent home with complicating diabetes insipidus and temporary mental change that disappeared 1 month later.

Histology: Sheets and cords of chief cells and transitional cells. Vascularity moderate. Stroma consists of a fair amount of fibrous tissue.

Specific stain (N.E.V.O.G.) shows a fair number of eosinophile cells in the compressed pituitary tissue adjacent to capsule.

1. Signs on right side of neck of neck ring

2. Findings are:

3. Locality of vision: left: 3/50; right: 5/15.

4. Bitemporal hemianopia.

5. Primary optic atrophy of moderate severity on the left side and fairly severe on the right.

6. Enormous enlargement of the sella turcica.

Diagnosis: Chromophobe adenoma.

Operation: Radical intra capsular extirpation of

chromophobe adenoma on 12.2.36.

Discharged, improved, 6.8.36.

Followed 6 years later in good condition.

Histology: Total cells. Sinusoidal pattern.

capillary form. Marked vascularity. Delicate

myelin perinuclear ether.

SERIAL NO. 50.  
HOSP. NO. 1196. (Mr Dott).  
R.C.P. NO. 9886/36.

MISS E.P.

Aged 41 years, ex-maternity nurse.

Nothing important to note in past history.

Examined on 27.7.36 for:

1. Amenorrhoea for 9 years.
2. Dimness of vision  $2\frac{1}{2}$  years.
3. Headache for 2 years.
4. Diplopia 6 weeks ago.
5. Lipoma on right side of back of neck for 9 months.

Positive findings are:

1. Acuity of vision: Left: 6/60; right: 6/18.
2. Bitemporal hemianopia.
3. Primary optic atrophy of moderate severity on the left side and fairly severe on the right.
4. Enormous enlargement of the sella turcica.

Diagnosis: Chromophobe adenoma.

Operation: Radical intra capsular extirpation of chromophobe adenoma on 18.8.36.

Discharged, improved, 8.9.36.

Followed 6 years later in good condition.

Histology: Fetal cells. Sinusoidal pattern.

Papillary form. Marked vascularity. Delicate hyaline perivascular stroma.

SERIAL NO. 51.  
HOSP. NO. 1210. (Mr Dott).  
R.C.P. NO. 9994/36.

MRS C.H.

Aged 60 years. Periods began at age of 14-15 years. Menopause at age of 43 years, has 4 sons.

Patient is asthmatic. Subject to attacks of epistaxis with the asthma.

Examination on 17.8.36 revealed:

Subjective:

1. Failure of vision for 1 year.
2. Occasional parasthesia along 5th nerve distribution.
3. Occasional diplopia.

Objective:

1. Diminished visual acuity.
2. Bitemporal hemianopia.
3. Diplopia.
4. Normal fundi.
5. Slightly expanded sella turcica.  
Plaque of calcification.

Diagnosis: ? aneurysm, ? epidermoid cyst,  
? meningioma.

Treatment: Operation on 6.9.36. Intracapsular extirpation of supra sellar pituitary adenoma.

Discharged on 25.9.36.

Followed in good condition till 18.3.43.

Histology: /

SERIAL NO. 51 (contd.)

Histology: Cords and sheets of chief cells.

Fetal cells. Moderate vascularity. Hyaline stroma.

Age of tumor.

Histology of tuberculous adenitis (cervical).

3/4

1. Subacute referred to trigeminal distribution for 1 year.
2. Deterioration of vision with dark spots for 1 year.
3. Right ptosis and squint that gradually improved, then recurred recently on left side.
4. Headaches for 4 months.

Examination on 1.9.36 revealed:

1. Acuity of vision: Right eye blind; left: 1/60.
2. Normal left field to confrontation.
3. Fundi; optic atrophies; not quite like an ordinary primary atrophy.
4. Left oculomotor paralysis.
5. X-ray appearance of a destructive lesion involving the sella turcica (malignant invasion of the base).

Diagnosis: Chordoid epithelioma.

Treatment: X-ray therapy. Recurrence with

symptoms of acromegaly on 11.5.37. Operation on

11.5.37. Intra capsular extirpation of intrasellar pituitary adenoma.

Histology: /

SERIAL NO. 52.  
HOSP. NO. 1220. (Mr Dott).  
R.C.P. NO. 2376/37, 2550/37.

MRS I.G.

Aged 48 years.

History of tuberculous adenitis (cervical).

C/O:

1. Parasthesia referred to trigeminal distribution for 1 year.
2. Deterioration of vision with dark spots for 1 year.
3. Right ptosis and squint that gradually improved, then recurred recently on left side.
4. Headaches for 9 months.

Examination on 1.9.36 revealed:

1. Acuity of vision: Right eye blind; left: 1/60.
2. Normal left field to confrontation.
3. Fundi; myopic astigmatism; not quite like an ordinary primary atrophy.
4. Left oculo-motor paralysis.
5. X-ray appearances of a destructing lesion involving the sella turcica (malignant invasion of the base).

Diagnosis: Pharyngeal endothelioma.

Treatment: X-ray therapy. Recurrence with symptoms of acromegaly on 11.3.37. Operation on 28.5.37. Intra capsular extirpation of intrasellar pituitary adenoma.

Histology: /



SERIAL NO. 52 (contd.)

Histology: Transitional cells; diffuse arrangement; scanty delicate stroma, poor vascularity.

No declared cells containing alpha granules.

Transitional cells seen to him 18 months ago.

Specimens on 30.10.55 for:

1. 5-6 years ago, patient had loss of sexual libido.
2. Headache 18 months ago.
3. Diminution of vision of right eye for 1 year.
4. Awareness of field defect after medical examination 9 months ago.
5. Diplopia, transient 6 months ago.
6. Ptosis and puffiness of right upper eyelid 3 months ago.

Positive findings are:

1. 4 orbital edema with slight exophthalmos of left eyeball.
2. Diminished visual acuity.
3. Bitemporal hemianopia, complete on right side.
4. Enlargement of both optic discs, more so on right.
5. Dilated right pupil.
6. Definite and complete right sixth nerve palsy.
7. X-ray of sella gives the impression of a supra-sellar type of tumour.

Diagnosis: /



SERIAL NO. 53.  
HOSP. NO. 1251. (Mr Dott).  
R.C.P. NO. 555/36.

H.L. (South Africa).

Male, aged 53 years, married.

Tonsillectomy done to him 18 months ago.

Examined on 30.10.36 for:

1. 5-6 years ago, patient had loss of sexual libido.
2. Headache 15 months ago.
3. Diminution of vision of right eye for 1 year.
4. Aware of field defect after medical examination 9 months ago.
5. Diplopia, transient 9 months ago.
6. Ptosis and puffiness of right upper eyelid 3 months ago.

Positive findings are:

1. ? orbital oedema with slight exophthalmos of left eyeball.
2. Diminished visual acuity.
3. Bitemporal hemianopia, complete on right side.
4. Pallor of both optic discs, more so on right.
5. Dilated right pupil.
6. Definite and complete right sixth nerve paresis.
7. X-ray of sella gives the impression of a supra sellar type of tumour.

Diagnosis: /

SERIAL NO. 53 (contd.)

Diagnosis: Supra sellar pituitary adenoma.

Operation: 6.11.36. Intracapsular extirpation  
cystic pituitary chromophobe adenoma.

N.B.: Patient received X-ray treatment before  
admission.

Recovered. In 15.6.37 developed mental and  
basal symptoms due to frontal abscess (mild residual  
post operative infection and cyst formation).

Histology: Cords and sheets of chief cells.  
Fetal cells with typical arrangement. Hyaline, but  
not dense stroma. Vascularity marked. Colloid  
cysts.

SERIAL NO. 54.  
HOSP. NO. 1252. (Mr Dott).  
R.C.P. NO. 580/36.

A.K. (South Africa).

Male, 19 years, single, did not shave yet.

Childhood ailments, appendicectomy.

Mother subject to attacks of headache.

C/O:

1. Headache 3 years ago.
2. Epistaxis 3 years ago.
3. Recurrent ptosis of right upper eyelid for 3-4 months.

Examination on 3.11.36 revealed:

1. Dyspituitarism (Frohlich's type).
2. Diminished visual acuity.
3. No field defect on confrontation or perimetry; but on screen there is a definite bitemporal hemianopia of an early type.
4. Dilated right pupil, ptosis of right eye, diplopia and divergent squint.
5. X-ray shows globular distension of sella turcica.

Diagnosis: Primary intra sellar tumour with evidence of supra sellar expansion clinically.

Operation on 11.11.36. Partial removal of unusual appearing pituitary tumour.

X-ray therapy.

Discharged /

SERIAL NO. 54 (contd.)

DOB: 20.11.1886. (Mr. Pitt).  
I.B.P. 20.12.36.

Discharged on 2.12.36. Died a year later of haemorrhage probably due to erosion of a blood vessel by part of the tumour.

Histology: Alveoli of chief cells; sinusoidal pattern; vascularity not marked; stroma delicate and trabecular.

1. Diminished sexual activity 3-6 years.

Positive findings are:

1. Dyspareunia.

2. Visual acuity: left: bare perception of light; right: 1/24 with difficulty.

3. Right temporal hemianopia.

4. Optic atrophy marked in left.

5. Grossly enlarged sella turcica with hyperostotic ballooning of the floor into underlying rather large sphenoidal sinus.

Diagnosis: Chromophobe adenoma.

Treatment: Best X-ray therapy before and after operation.

Operation on 2.12.36. Intracapsular extirpation of chromophobe adenoma.

Discharged improved on 22.12.36.

Histology: cords and sheets of chief cells. Sinusoidal pattern. Poor vascularity. Dense hyaline fibrous stroma.

SERIAL NO. 55.  
HOSP. NO. 1265. (Mr Dott).  
R.C.P. NO. 869/36.

S. McL. T. (South Africa).

Male, 53 years old, clerk, married and has 4 sons.

Attacks of jaundice, typhoid and rheumatism.

Examined on 2.12.36 for:

1. Failure of vision for 2 years.
2. Diminished sexual activity 5-6 years.

Positive findings are:

1. Dyspituitarism.
2. Visual acuity: Left: bare perception of light; right: 1/24 with difficulty.
3. Right temporal hemianopia.
4. Optic atrophy marked in left.
5. Grossly enlarged sella turcica with hemispherical ballooning of the floor into underlying rather large clear sphenoidal sinus.

Diagnosis: Chromophobe adenoma.

Treatment: Deep X-ray therapy before and after operation.

Operation on 9.12.36. Intracapsular extirpation of chromophobe adenoma.

Discharged improved on 22.12.36.

Histology: Cords and sheets of chief cells. Sinusoidal pattern. Poor vascularity. Dense hyaline fibrous stroma.



SERIAL NO. 56.  
HOSP. NO. 1278. (Mr Dott).  
R.C.P. NO. 1073/37.

J.B.E. (South Africa).

Male, aged 48 years, married, has one boy of  
3 years.

Nothing important in past history to note.

C/O:

1. Occasional diplopia 4 months ago.
2. Gradual deterioration of vision since then.

Examined on 5.1.37 and the following positive  
findings were noted:

1. Diminished visual acuity.
2. Bitemporal hemianopia.
3. Slight pallor of both discs within normal  
limits.
4. Notable expansion of the sella turcica.

Diagnosis: Chromophobe adenoma.

Operation: 10.1.37 subtotal extirpation of  
chromophobe adenoma (transfrontal route).

12.1.37: Bilateral decompression for post  
operative traumatic cerebral oedema.

Died on 14.1.37 with suspected massive pulmonary  
embolism.

Histology: /



SERIAL NO. 56 (contd.)

H.S.S. No. 2504/57.

Histology: Cords and sheets of chief cells.

Sinusoidal arrangement. Marked vascularity.

Foetal cells with the perivascular pattern.

Stroma shows hyaline degeneration. No excessive

fibrosis. No mitosis.

- 1. Enlargement of nasal parts 6 years ago.
- 2. Blindness 2-3 years.
- 3. Loss of sexual potency and libido with gradual hypersexualisation.
- 4. Increase in weight for 2-3 years.
- 5. Failure of vision for 4 years.
- 6. Headache 1 year ago.

Typical findings are:

- 1. Acromegalic features.
- 2. Considerable failure of vision in left eye.
- 3. Absolute bilateral hemianopia.
- 4. Pale discs, but defined in outline.
- 5. Acromegalic nose - cells turqiva enlarged
- 6. Sclerotic ring.

Diagnosis: Acromegalic adenoma.

Operation on 14.3.57. Transphenoidal sellar

decompression - Hooper.

1-radiation therapy.

Discharged /

SERIAL NO. 57.  
HOSP. NO. 1347. (Mr Dott).  
R.C.P. NO. 2504/37.

W.R.

Male, 36 years old, married, 4 of a family,  
youngest 2 years.

Examined on 9.5.37 for:

1. Enlargement of acral parts 8 years ago.
2. Lassitude 2-3 years.
3. Loss of sexual potency and libido with gradual hypersomnolence.
4. Increase in weight for 2-3 years.
5. Failure of vision for 4 years.
6. Headache 1 year ago.

Positive findings are:

1. Acromegalic features.
2. Considerable failure of vision in left eye.
3. Absolute bitemporal hemianopia.
4. Pale discs, but defined in outline.
5. Acromegalic bones - sella turcica enlarged in a globular form.

Diagnosis: Eosinophile adenoma.

Operation on 14.5.37. Transphenoidal sellar  
decompression - Biopsy.

X-radiation therapy.

Discharged /

SERIAL NO. 57 (contd.)

ROSE, NO. 1206 (Dr. Dettl.)

Discharged on 29.5.37 and followed till 26.5.41.

Histology: Transitional cells with abundant admixture of eosinophile cells. Compact or diffuse pattern. Scanty delicate stroma. Poor vascularity. Specific stain (N.E.V.O.G.) shows alpha granules.

1. Increased headaches for 1 year.

2. Anosmia for 2 years.

3. Fat deposit in face and increase in weight for 2 years.

4. Increased size of hands and feet 33 months.

Examination on 4.4.37 revealed:

1. No acromegalic features.

2. General depression of fields of vision with definite bitemporal hemianopia.

3. Hypoplasia uterina - scanty endometrium, no eversion of gonadotropic hormone in the urine.

4. Basal metabolic rate + 11%.

5. X-ray appearances are compatible with a relatively early sellar pituitary enlargement.

Diagnosis: Chromophobe adenoma with hypopituitarism.

Operation on 2.8.37 (subtotal extirpation of pituitary adenoma. Right transfrontal procedure).

Discharged, ✓

SERIAL NO. 58.  
HOSP. NO. 1355. (Mr Dott).  
R.C.P. NO. 2432/37.

H.M.

Female, 23 years old, single, periods began at age of 14 and were regular. Subject to headaches.

C/O:

1. Increased headaches for 2 years.
2. Amenorrhoea for 2 years.
3. Fat deposit in face and increase in weight for 2 years.
4. Increased size of hands and feet 18 months.

Examination on 6.4.37 revealed:

1. No acromegalic features.
2. General depression of fields of vision with definite bitemporal hemianopia.
3. Hypoplastic uterus - scanty endometrium. No excretion of gonadotropic hormones in the urine.
4. Basal metabolic rate + 11%.
5. X-ray appearances are compatible with a relatively early sellar pituitary enlargement.

Diagnosis: Chromophobe adenoma with hypopituitarism.

Operation on 2.6.37 (subtotal extirpation of pituitary adenoma. Right transfrontal procedure).

Discharged, /

SERIAL NO. 58 (contd.)

H.C.S. No. 137. (St. 1011).

H.O. No. 137/51.

E.P.B. No. 137/51.

P.M. No. 137/51.

Discharged, improved, on 19.6.37.

Re-admitted on 25.11.42 with scleroderma and patchy myxoedema.

Histology: Chief cells in a diffuse pattern.

Poor vascularity. Scanty delicate stroma. Specific stain (E.P.B.) shows no granules.

Examination on 19.5.37 revealed the following

positive findings:-

Subjective:-

1. Defective vision for 4 years.
2. Diminished sexual functions in the last 6 months.

Objective:-

1. Dyspituitarism (poor secondary sexual characteristics).
2. No light perception in left eye. Right is J16 and 5/18.
3. Definite right temporal hemianopia.
4. Sluggish pupillary reactions.
5. ? Right lower facial weakness.
6. Poor tendon reflexes and ankle jerks.
7. Enlarged cells.

Diagnosis: Epidermoid tumour.

Operation: /



SERIAL NO. 59.  
HOSP. NO. 1358. (Mr Dott).  
R.C.P. NO. 2457/37.  
N.P. NO. 741.  
P.M. NO. RIE/288/37.

R.B.

Male, aged 52 years, married at age of 47, wife never got pregnant. Shaves twice a week only.

History of rheumatism, and renal calculi.

Examination on 18.3.37 revealed the following positive findings:-

Subjective:-

1. Defective vision for 4 years.
2. Diminished sexual functions in the last 6 months.

Objective:-

1. Dyspituitarism (poor secondary sexual characteristics).
2. No light perception in left eye.  
Right is J16 and 6/18.
3. Definite right temporal hemianopia.
4. Sluggish pupillary reactions.
5. ? Right lower facial weakness.
6. Poor tendon reflexes and absent ankle jerks.
7. Enlarged sella.

Diagnosis: Epidermoid tumour.

Operation: /



SERIAL NO. 59 (contd.)

Operation: Thorough intracapsular extirpation of large pituitary adenoma on 4.6.37.

Died on 9.6.37. Haemorrhage occurred 5 years ago.

Histology: Sheets of chief cells. Sinusoidal pattern. Marked vascularity. Hyaline fibrous stroma. Haemorrhage into the tumour. relieved by vomiting, 4 months ago.

1. Unconsciousness 2 weeks ago.

2. Unsteady gait, 3 months ago.

Examination revealed: Patient is drowsy with:

1. Visual acuity: Right: 3/36 - J10;  
left: 3/36 - J15.

2. Right primary optic atrophy with early edema. Left suggestive of secondary optic atrophy.

3. Bitemporal hemianopia.

4. Poor pupillary reactions. Irregularity of their shape.

5. Rhythmic tremors in tongue.

6. Disorientation, defective memory for recent events.

7. Doubtful polydipsia.

8. Hyperreflexia of all limbs. brisk tendon reflexes and Babinski +.

9. Considerable enlargement and bony absorption of the sella turcica.

Diagnosis: /

SERIAL NO. 60.  
HOSP. NO. 1429. (Mr Dott).  
R.C.P. NO. 3595/37.

MISS E.C.

Aged 50 years. Menopause occurred 5 years ago.

Admitted on 28.9.37.

C/O:

1. Occasional frontal headaches relieved by vomiting, 4 months ago.
2. Unconsciousness 2 weeks ago.
3. Unsteady gait, 3 months ago.

Examination revealed: Patient is drowsy with:

1. Visual acuity: Right: 3/36 - J20;  
left: 2/36 - J18.
2. Right primary optic atrophy with early oedema. Left suggestive of secondary optic atrophy.
3. Bitemporal hemianopia.
4. Poor pupillary reactions. Irregularity of their shape.
5. Rhythmic tremors in tongue.
6. Disorientation, defective memory for recent events.
7. Doubtful polydipsia.
8. Hypertonus of all limbs. Brisk tendon reflexes and Babinski +.
9. Considerable enlargement and bony absorption of the sella turcica.

Diagnosis: /

SERIAL NO. 60 (contd.)

Diagnosis: Supra sellar cyst complicated by obstructive hydrocephalus.

Operation on 29.9.37. Subtotal removal of pituitary tumour. Improved and discharged.

Recurrence on 21.8.40.

Histology: Chief cells. Diffuse arrangement. Moderate vascularity. Fine reticular stroma. E.P.B. stain reveals no alpha granules.

SERIAL NO. 61.  
HOSP. NO. 1452. (Mr Dott).  
R.C.P. NO. 4238/37.

R.T.

Male, aged 47 years, married for 5 years, no children. Joiner and then gardener.

Past history of sciatica and of herniotomy.

C/O:

1. Failure of vision 14 months ago with attacks of diplopia.

Examination on 28.10.37 revealed:

1. Moderately advanced right optic atrophy.
2. Right central scotoma, left central sparing.
3. Diminished acuity of vision (left: 6/18; right: 5/60).
4. Parasthesia on right cheek.
5. X-ray appearances are those of chronic and long standing intra sellar enlargement.

Diagnosis: Chromophobe adenoma.

Operation: 24.11.37. Subtotal intracapsular extirpation of chromophobe adenoma.

X-ray therapy followed.

Discharged on 9.12.37, developed slight myxoedema. Followed till 24.10.46.

Histology: Cords of chief cells - sinusoidal pattern with papillary arrangement. Scanty delicate stroma. Vasculature not marked. Specific stain (E.P.B.) shows no granules.

SERIAL NO. 62.  
HOSP. NO. 1465. (Mr Dott).  
R.C.P. NO. 4268/37.

W.C.H. (South Africa).

Male, aged 42 years, linesman in tramway company.  
Began to shave at age of 18 years (once a week), now  
he shaves every other day.

History of accident 7 years ago.

Examined on 11.11.37.

C/O:

1. Deterioration of vision for 6 months.
2. Pain behind the eyes 12 months ago.
3. Loss of sexual desire for 6 months.
4. Headache for 2 months.

Positive signs are:

1. Diminished visual acuity (left eye counts fingers).
2. Bilateral temporal hemianopia.
3. Suggestion of right lower facial weakness.
4. Gross enlargement of the sella by a primarily intra sellar tumour.

Diagnosis: Chromophobe adenoma.

Operation on 28.11.37. Subtotal intra capsular  
extirpation of adenoma.

X-ray treatment followed.

Discharged /



SERIAL NO. 62 (contd.)

Discharged, improved, on 6.12.37.

Histology: Chief cells. Diffuse pattern.

Dense fibrous stroma. Poor vascularity. Lymphocytic aggregations. Specific stain (E.P.B.) shows no granules.

Subject of convulsive attacks during childhood. Examination on 6.12.37 revealed:

Subjective:

1. Amenorrhoea 13 years, with sudden increase in weight.
2. Diplopia 23 months ago.
3. Headaches 25 months ago.
4. Deterioration of vision for 3 months.
5. Lassitude and loss of memory for 1 year.

Objective:

1. Dyspituitarism (obesity - hair).
2. Diminished visual acuity.
3. Bitemporal hemianopia.
4. Parasthesias of first division of right trigeminal nerve.
5. Considerably expanded sella turcica.

Diagnosis: /

SERIAL NO. 63.  
HOSP. NO. 1474. (Mr Dott).  
R.C.P. NO. 4453/37.  
N.P. NO. 858.  
P.M. Private /37.

MISS D.W.

Aged 43 years, works in textile machine making.  
Periods started at age of 13 years and ceased at age  
of 30 years.

Subject of convulsive attacks during childhood.

Examination on 6.12.37 revealed:

Subjective:

1. Amenorrhoea 13 years, with sudden increase in weight.
2. Diplopia 23 months ago.
3. Headaches 22 months ago.
4. Deterioration of vision for 3 months.
5. Lassitude and loss of memory for 1 year.

Objective:

1. Dyspituitarism (obesity - hair).
2. Diminished visual acuity.
3. Bitemporal hemianopia.
4. Parasthesias of first division of right trigeminal nerve.
5. Considerably expanded sella turcica.

Diagnosis: /

SERIAL NO. 63 (contd.)

Diagnosis: Chromophobe adenoma.

Operation:

Died: 46 years, has family of five. Menopausal

Histology: Chief cells. Sinusoidal pattern in the periphery and diffuse in the centre. Areas of dense fibrous stroma. Markedly vascular with areas of haemorrhage. No granules seen with E.P.B. stain. Colloid degeneration in tumour.

1. Deterioration of vision 6 months ago with periodical diplopia.
2. Polydipsia for 3 weeks.
3. Transient incontinence for 6 months.

Positive findings are:

1. Diminished visual acuity.
2. Bitemporal hemianopia.
3. X-ray appearances suggest a large primarily intra-sellar growth.

Diagnosis: Chromophobe pituitary adenoma.

Treated by radical suprasellar extirpation (right transfrontal approach).

Discharged, improved, on 7.1.53.

Histology: Sheets of chief cells. Foetal cells. Sinusoidal pattern. Perivascular palisading. Fairly dense fibrous hyaline stroma. Poor vascularity. Specific stain (E.P.B.) shows no granules.

SERIAL NO. 64.  
HOSP. NO. 1475. (Mr Dott).  
R.C.P. NO. 4454/37.

MRS M.R.

Aged 56 years, has family of five. Menopause  
10 years ago.

Subject to attacks of headache in the last 30  
years.

Examined on 4.12.37.

C/O:

1. Deterioration of vision 6 months ago with  
periodical diplopia.
2. Polydipsia for 3 weeks.
3. Transient insomnia for 6 months.

Positive findings are:

1. Diminished visual acuity.
2. Bitemporal hemianopia.
3. X-ray appearances suggest a large primarily  
intra sellar growth.

Diagnosis: Chromophobe pituitary adenoma.

Treated by radical capsular extirpation (right  
transfrontal approach).

Discharged, improved, on 7.1.38.

Histology: Sheets of chief cells. Foetal cells.  
Sinusoidal pattern. Perivascular palisading.  
Fairly dense fibrous hyaline stroma. Poor vascular-  
ity. Specific stain (.E.P.B.) shows no granules.

SERIAL NO. 65.  
HOSP. NO. 1491. (Mr Dott).  
R.C.P. NO. 4882/38.

T.J.R. (South Africa).

Male, aged 45 years, married, three sons, farmer.

Nothing important to note in past history.

Examined on 3.1.38.

C/O:

1. Deterioration of vision 2 years.
2. Lassitude for 6 months.

Positive findings are:

1. Diminished acuity of vision on right side.
2. Scotomatous temporal hemianopia on left side.
3. X-ray shows decalcification of dorsum and appearances suggestive either of general increase in intra cranial pressure or of supra pituitary tumour.

Diagnosis: Adenoma of moderate size.

Operation: Subtotal extirpation of pituitary chromophobe adenoma on 14.1.38.

X-ray treatment followed.

Discharged in good condition on 5.3.38.

Histology: Chief cells. Sinusoidal arrangement peripherally and diffuse pattern centrally. Fairly fibrous, hyaline stroma. Poor vascularity. No granules (N.E.V.O.G. stain).



SERIAL NO. 66.  
HOSP. NO. 1520. (Mr Dott).  
R.C.P. NO. 5656/38.

**B.K.** (South Africa).

Male, aged 53, married, has children.

Past history of malaria with recurrence.

Lightning accident 20 years ago.

Examined on 12.3.38 for:

1. Deterioration of vision for 6 years, ending by total blindness of the right eye in the last 2 years.
2. Increase in weight for 4-5 months.

Positive signs are:

1. Visual acuity: Right: no light perception; left: 6/36.
2. Complete left temporal hemianopia.
3. Right primary optic atrophy; pallor of temporal part of left disc.
4. Transient divergent squint due to lack of fixation.
5. Loss of tone in left facial.
6. Slight hypertonus and disability of left extremities. Brisk tendon reflexes, positive Rossolimo depressed abdominal reflexes on left side, hemispastic gait. Euphoria.
7. Extensive enlargement of the sella turcica.

Diagnosis: Chromophobe adenoma.

Operation /

SERIAL NO. 66 (contd.)

Operation on 1.4.38. Intra capsular removal of very large pituitary adenoma. (Right transfrontal procedure).

Discharged, improved, on 11.5.38.

Followed till 20.11.45.

Histology: Foetal cells. Papillary arrangement, compressed papillae in centre. Vasculature not marked. Slight perivascular hyalinosis.

SERIAL NO. 67.  
HOSP. NO. 1576. (Mr Dott).  
R.C.P. NO. 8970/41.

C.C.

Male, aged 15 years, works in the Navy.

History of tuberculosis among relatives.

Mother died of thyroid trouble.

Nothing important to note in past history.

Admitted on 25.6.38.

C/O:

1. Rapid growth and clumsiness 2 years ago.
2. Polyuria and polydipsia 11 months ago.
3. ? Rheumatic pains in joints 3½ months.
4. Occasional haziness in front of his eyes.

Examination revealed:

1. Dyspituitarism (Frohlich's type together with acromegaly).
2. Head mild oxycephaly.
3. Visual acuity: 6/6 J1 uncorrected, both sides.
4. Bilateral upper quadrantic field defect.
5. No trace of optic atrophy.
6. Basal metabolic rate -6%, blood sugar curve, slightly decreased threshold for sugar and shows the features of a lag curve.
7. Sella enlarged and deep.

Treatment: /

SERIAL NO. 67 (contd.)

Treatment: X-ray therapy.

Gradual progression of symptoms with deterioration of sight.

Operation on 10.9.41. Transphenoidal decompression.

Died in coma on 12.9.41.

Histology: Mainly transitional cells. Few isolated eosinophile cells. Little mitosis. Multinucleated cells are apparent. Vascularity marked with old and fresh haemorrhages. Stroma shows hyaline interlobular septa.

SERIAL NO. 68.  
HOSP. NO. 1594. (Mr Dott).  
R.C.P. NO. 7581/38.

T.R.G.

Male, aged 55 years, married, has children.

Nothing important to note in past history.

Examined on 11.8.38 for:

1. Deterioration of vision  $2\frac{1}{2}$  years ago.
2. Failure of sexual power for the last 2 years.
3. Slight nocturnal frequency of micturition for 2-3 weeks.

Positive signs are:

1. Diminished visual acuity: Right: 1/60;  
left: 3/60.
2. Optic atrophy.
3. Bitemporal hemianopia with centro-coecal scotoma on each side.
4. Generalised symmetrical hyperreflexia.
5. Enlarged sella turcica due to intra sellar tumour.

Diagnosis: Chromophobe adenoma.

Operation: Left transfrontal pituitary exposure on 12.9.38 and intra capsular extirpation of tumour on 21.9.38.

Discharged on 1.10.38 and followed till 9.3.40.

Histology: Foetal cells. Characteristic perivascular papillary pattern. Marked vascularity. Hyaline delicate stroma. No granules (E.P.B. stain).



SERIAL NO. 69.  
HOSP. NO. 1619. (Mr Dott).  
R.C.P. NO. 8291/38.

A.B.C. (South Africa).

Male, aged 45 years, married, has children.

Nothing important to note in past history.

Examined on 18.10.38 for:

1. Did not shave till age of 20 years.
2. Increase in weight at age of 30 years.
3. Reduced sexual activity during past 15 years.
4. Deterioration of vision for 18 months.
5. Occasional diplopia.
6. Polydipsia, no tendency to polyuria.

Positive findings are:

1. Hypopituitarism.
2. Diminished visual acuity.
3. Bitemporal hemianopia.
4. Optic discs perhaps on the pale side but not definitely abnormal.
5. Sellar cavity not unusually large, compatible with supra sellar tumour.

Diagnosis: Epidermoid cyst.

Operation 18.11.38. Subtotal intracapsular extirpation of cystic and solid chromophobe adenoma.

Discharged on 25.12.39.

Histology: /

SERIAL NO. 69 (contd.)

Histology: Groups of chief cells. Few mitosis. Sinusoidal pattern. Vascularity not marked. Stroma delicate. Colloid cysts visible in the tumour.

SERIAL NO. 70.  
HOSP. NO. 1655. (Mr Dott).  
N.P. NO. 1098.  
P.M. NO. RIE 588/38.

J.M.

Male, aged 36 years, railway clerk, married for 10 years.

Nothing to note in past history.

Examination on 7.11.38 revealed:

Subjective:

1. Diminished sexual activity for 5 years.
2. Lack of energy for 9 months.
3. Diplopia 5 months ago.
4. Deterioration of sight 5 months ago.

Objective:

1. Bitemporal hemianopia.
2. Diminished visual acuity.
3. Pallor of left field compared to the right.
4. Appearances, in X-ray, typical of intrasellar tumification.

Diagnosis: Pituitary adenoma.

Operation: 5.12.38. Intracapsular extirpation of pituitary adenoma.

Died on 8.12.38.

Histology: /

SERIAL NO. 70 (contd.)

Histology: Strands of chief cells. Sinusoidal pattern, tendency to papilliform appearance. Moderate vascularity. Stroma delicate. Central necrosis. Dense fibrous capsule.

Nothing important to note in last section.

Admitted to 1014-45.

2/01

- 1. Enlargement of vessels in left eye and 2. right eye.
- 2. Blind spot in the field of vision in right eye 4-5 degrees high.
- 3. Enlarged base of nasal cavity.

Examination revealed:

- 1. Both eyes are slightly red.
- 2. Right upper eyelid swollen and red. Long dark crusts in lower conjunctival sac. Left ocular conjunctiva normal.
- 3. Slight cotton wool in both eyes.
- 4. C.S.F. normal protein content and cell count. Negative for bacteria and fungi.
- 5. Denudation of posterior cornea. Flattening of globe and hyperopia of 10 diopters.

Diagnosis: Meningitis, chronic, pyogenic.

Cholesterolemia, negative.

Operation on 2.1.45. Successful drainage of

chronic meningitis.

Discharged /

SERIAL NO. 71.  
HOSP. NO. 1892. (Mr Dott).  
R.C.P. NO. 3666/40.

J.B.

Male, aged 64 years, secretary, married, has children.

Nothing important to note in past history.

Admitted on 16.4.40.

C/O:

1. Haziness of vision in left eye for 1 year.
2. Blind spot in the field of vision in right eye 6-7 months ago.
3. Recent loss of sexual activity.

Examination revealed:

1. Both discs are slightly pale.
2. Right upper outer quadrant defect with a large dense scotoma in centro-coecal area. Left definite temporal hemianopia.
3. Slight action tremor in both hands.
4. C.S.F. normal protein content and cell count. Negative W.R. and gold reaction.
5. Decalcification of posterior clinoids. Floor of sella and tuberculum sellae normal.

Diagnosis: Meningioma, adenoma, epidermoid, cholesteatoma, aneurysm.

Operation on 24.4.40. Subtotal extirpation of supra sellar pituitary adenoma.

Discharged /



SERIAL NO. 71 (contd.)

Discharged on 20.5.40.

Histology: Cords and groups of chief cells.  
Sinusoidal arrangement. Papilliform projections.  
Hyaline fibrous stroma. Marked vascularity.  
Colloid cysts. No specific granules (N.E.V.O.G.  
E.P.B.).

SERIAL NO. 72.  
HOSP. NO. 1893. (Mr Dott).  
R.C.P. NO. 3700/40.

M.C.

Male, 58 years, single.

History of sciatica. Rheumatism and bleeding gastric ulcer.

Examined on 17.4.40 for:

1. Deterioration of vision 19 months.
2. Occasional headache 1 month.
3. Attack of severe pain in head 1 week.

Positive findings are:

1. Hand movements and light perception in each eye.
2. Bitemporal hemianopia.
3. Primary optic atrophy.
4. Absent ankle jerks on both sides.
5. Blood count: HB: 80%; RBC's: 4,060,000;  
C.I.: 0.99; WBC's: 7800. Reticulo cytes more than 1%. Platelets 200,000.
6. C.S.F. normal protein content. Negative W.R. and colloid gold reaction.
7. X-ray appearances of intrinsic lesion of the sella turcica.

Operation on 26.4.40. Transphenoidal decompression. Biopsy. Opening of pituitary cyst (bulging to sphenoidal sinus).

Discharged /

SERIAL NO. 72 (contd.)

Discharged on 16.5.40.

Histology: Foetal cells. Typical perithelial arrangement. Moderate vascularity. Delicate strands of fibrous stroma tunnelled by thin capillaries. Colloid vesicles. No malignancy.

SERIAL NO. 73.  
HOSP. NO. 1904. (Mr Dott).  
R.C.P. NO. 7920/41 - 6169/44.

W.C.

Male, 30 years, single.

Nothing important to note in past history.

Examined on 20.6.39 for:

1. Increase in weight for  $6\frac{1}{2}$  years.
2. Enlargement of acral parts and nose.
3. Headaches.
4. Ear aches for 2-3 months.

Positive findings are:

1. Visual acuity: Left: 6/6; right: 6/12.
2. Bitemporal hemianopia with central sparing.
3. Acromegalic features.
4. Enlargement of sella turcica and development of frontal sinuses.

Treated by X-ray in 1934. On 8.5.41 definite deterioration of vision.

Operation on 10.6.41. Transphenoidal decompression and partial removal of pituitary adenoma.

Discharged on 28.6.41.

Recurrence: Operation on 13.9.44. Transfrontal intra capsular removal of pituitary eosinophil adenoma; X-ray treatment followed.

Histology: /

SERIAL NO. 73 (contd.)

Histology: 1st biopsy: Foetal and transitional cells. Diffuse pattern, delicate stroma, little mitosis. Scanty eosinophil cells.

2nd biopsy: Degenerating pyknotic cells. No alpha granules (N.E.V.O.G. stain). Slight fibrosis and hyalinosis.



SERIAL NO. 74.  
HOSP. NO. 1928. (Mr Dott).  
R.C.P. NO. 4828/40.

A.W.

Female, aet 48 years. Periods ceased at the age of 42 years.

Nothing important to note in past history.

Examined on 27.7.40 for:

1. Episodes suggesting left retinal vaso spasm 4-5 years ago.
2. Fluctuation of weight for 2 years.
3. Poor memory 2 years ago.
4. Frontal headache for 1 year.
5. Deterioration of sight in left eye for 1 year.

Positive findings are:

1. Visual acuity: Left eye: hand movements; right: 6/18 - J10.
2. Fields: Right: general depression; left: only crescentic peripheral nasal island remains.
3. Fundi: Left arteries very narrow and in part practically obliterated. Nerve head atrophic.
4. X-ray characteristic of an intra sellar expanding lesion.

Diagnosis: Chromophobe adenoma.

Operation on 23.8.40. Transphenoidal sellar decompression. Biopsy.

Discharged /

SERIAL NO. 74 (contd.)

Discharged on 18.9.40. Improved vision.

\* Histology: Groups of chief cells. Sinusoidal pattern. Tendency to acinar arrangement. Poor vascularity. Scanty delicate stroma. Colloid vesicles.

SERIAL NO. 75.  
HOSP. NO. 1968. (Mr Dott).  
R.C.P. NO. 5290/40.

MRS. M.D.

Aet 49, has 3 children; last 15 years ago.

Nothing important to note in the past history.

Examined on 24.9.40 for:

1. Undue persistence of milk after lactation for 8-10 years.
2. Amenorrhoea since last pregnancy for 15 years.
3. Deterioration of vision for 10 years.
4. Sudden access in weight.
5. Attacks of flushing and sweating for 3 years.
6. Loss of memory. Hypersomnolence, lassitude for 1 year.

Positive findings are:

1. Dyspituitarism.
2. Left side anosmia.
3. Slight increase of knee and ankle jerks on left side.
4. Left Babiniski.
5. Bilateral familial congenital claw-foot.
6. X-ray shows entire absence of dorsum sellae, and depression of the floor of sella turcica.

Operation on 14.10.40. Transphenoidal sellar decompression.

Discharged /

SERIAL NO. 75 (contd.)

Discharged on 9.11.40.

Recurrence: Completely blind with bilateral optic atrophy on 14.11.42. (2 years later.) No active treatment done.

Histology: Chief cells. Diffuse pattern. Delicate stroma in the ~~ma~~major part. No marked vascularity. Cholestrol spaces surrounded by foreign body giant cells.

SERIAL NO. 76.  
HOSP. NO. C171. (Mr Dott).  
R.C.P. NO. 7406/41.

MISS G.D.

Aet 41 years, clerkess. Periods began at age of 14 years, regular till age of 21, then irregular in quantity and time.

Nothing important to note in previous illnesses.

Admitted on 29.3.41.

C/O:

1. Amenorrhoea for 6 years.
2. Twitchings and tingling in left side 6 years ago.
3. Deterioration of vision.
4. Headaches.
5. Large hands and feet for 20 years.

Examination revealed:

1. Enlarged hands and feet. Hyperostosis of pharyngeal articulation. Slight jutting of frontal sinuses. Heaviness of the lower jaw. Hypertrichosis: thighs and legs. Pubic hair feminine. Build tends to be masculine.
2. High blood pressure (220/150).
3. Slight mental deterioration.
4. Marked atrophy of left fundus. Bitemporal hemianopia. Diminished visual acuity: Left: 6/12; right: 2/9. Sluggish unequal pupils.
- 5./



SERIAL NO. 76 (contd.)

5. Arteriograms: Showed deformity in the stem of the carotid characteristic of a large supra sellar mass.

Diagnosis: Intra and supra sellar pituitary tumour.

Operation on 25.4.41. Intracapsular removal of adenoma.

Died on 28.4.41 with an episode of general convulsive movements and meningitis.

Histology: Chief cells. Diffuse pattern. No marked vascularity. Stroma scanty and slightly hyaline. No granules (E.P.B., N.E.V.O.G. stains).

SERIAL NO. 77.  
HOSP. NO. C179. (Mr Dott).  
R.C.P. NO. 7006/41.

MRS N.C.

Aet 42 years, menstruation at age of 15 years.

Ceased 2 years ago.

Nothing important to note in past history.

Examined on 7.3.41.

C/O:

1. Increase in size of acral parts together with fatigue and nervousness for  $2\frac{1}{2}$  years.
2. Headaches for  $2\frac{1}{2}$  years.
3. Tinnitus for  $2\frac{1}{2}$  years.
4. Increase in weight.
5. Transient diplopia experienced once.
6. Defective vision.
7. Tendency to fall backwards or to the right, for one week.

Positive findings are:

1. Acromegolic features.
2. Dyspnoea and cyanosis.
3. Diminished acuity of vision: Left: 6/60 - J.12; right: 6/9 - J.1 (corrected). Bitemporal hemianopia much more advanced in left eye. Fundi pale and atrophic.
4. Moderate globular enlargement of the sella turcica with thinning of the floor.

Diagnosis: /

SERIAL NO. 77 (contd.)

Diagnosis: Eosinophil pituitary adenoma. Had X-ray treatment with amelioration of symptoms.

Operation on 21.3.41. Transphenoidal sellar decompression. Biopsy.

Discharged on 26.4.41.

Histology: Mixed transitional and eosinophil cells. Scanty stroma. Sinusoidal architecture. No marked vascularity.

SERIAL NO. 78.  
HOSP. NO. C382. (Mr Dott).  
R.C.P. NO. 8830/41.

W.P.

Male, aet 43 years, miner, married, 2 boys.

Past history of pneumonia and rheumatism.

Examined on 24.7.41 for:

1. Headaches, 7 years ago.
2. Momentary dizziness, 7 months ago.
3. Failure of vision, 7 months ago, starting in left.
4. Increase in weight in last 3 years.

Positive signs are:

1. Diminished visual acuity: Left: 6/9 - J.1;  
right: 6/12 - J.2.
2. Absolute temporal hemianopia with minute central sparing in the right eye.
3. Enlarged and deeply excavated sella turcica (appearances are those of an intra sellar tumour).

Diagnosed as: Chromophobe adenoma.

Operation on 24.8.41. Followed 2 years later.

Histology: Foetal cells. Papillary arrangement.

No mitosis. Delicate hyaline stroma. No marked vascularity. No granules (N.E.V.O.G., E.P.B. stains).

SERIAL NO. 79.  
HOSP. NO. C399. (Mr Dott).  
R.C.P. NO. 8803/41, 975/45.

MISS A.K.

Aged 49 years, domestic servant, periods began at age of 14 years (scanty, irregular).

Cholecystectomy done to her 12 years ago for stones.

Examined on 22.7.41.

C/O:

1. Amenorrhoea 2-3 years ago.
2. Deterioration of vision for 2 years.
3. Continuous headache for 18 months.
4. Diplopia 18 months ago.
5. Polyuria several years.
6. Adiposity for 3 years.

Positive findings are:

1. Hypopituitarism (skin - hair).
2. Diminished visual acuity: Right: 6/9;  
left: 6/18 (corrected).
3. Bitemporal hemianopia.
4. Temporal pallor of the left disc.
5. Gross enlargement of the pituitary fossa.  
Tumour extends to sphenoidal air sinus.

Diagnosis: Pituitary chromophobe adenoma.

Operation on 20.8.41. Transphenoidal decompression and partial extirpation of adenoma.

Discharged /



SERIAL NO. 79 (contd.)

Discharged home on 14.9.41.

Recurrence on 31.4.45. Operation on 13.6.45.

Transfrontal exposure of pituitary, clearing out of large cyst and adenoma. Followed till 17.9.46 in good condition.

Histology: Both biopsies show foetal cell type. Typical perivascular arrangement. Papilliform architecture. Hyaline connective tissue core. Thin walled capillaries. No mitosis. No granules detected (E.P.B. stain).

SERIAL NO. 80.  
HOSP. NO. C439. (Mr Dott).  
R.C.P. NO. 1728.  
P.M. NO. EH/58/A.

T.B.

Male, aged 32 years, married, 3 children.

No previous illnesses of importance to note.

Mother died of cancer of breast.

Examined on 1.5.41 for:

1. Swelling of the hands and feet with stiffness and sweating for 2 years.
2. Headache 3 weeks ago.
3. Tinnitus for 4 weeks.
4. Increase in weight with hypersomnolence.
5. Polydipsia and polyuria for 4 months.
6. Deterioration of vision for 2 months.

Positive findings are:

1. Typical acromegaly.
2. Anosmia on right side.
3. Visual acuity: Right: 6/5 - J1; left: 6/6 - J1.
4. Bilateral papilloedema. Full fields.
5. Indrawn drum on right side.
6. Blood sugar curve:  
Fasting 83 - 99 - 125 - 99 - 83 mgm %.  
Urine showed no sugar in fasting specimen,  
but a trace in the second sample.

7. /

SERIAL NO. 80 (contd.)

7. Basal metabolic rate + 7%.

8. C.S.F. and blood present normal pictures.

9. Enlarged sella turcica.

Operation on 13.5.41. Right frontal osteo-  
plastic decompression bone flap.

Died on 17.5.41.

Histology: Mixed chief cells. Transitional  
cells and eosinophiles. Sinusoidal pattern.  
Necrosis. Haemorrhages. Delicate hyaline stroma.  
Multi-nucleated cells. Vascular.

SERIAL NO. 81.  
HOSP. NO. C472. (Mr Dott).  
R.C.P. NO. 9682/41.

MISS G.P.

Aged 67 years. Periods began at the age of 13 years. Stopped abruptly at the age of 43 years.

Sister died of tumour of bowel. Mother migranous.

Past history of rheumatism.

Examined on 20.10.41 for dimness of vision for six months. The following findings noted:

1. Depressed sense of smell on the left side.
2. Visual acuity 6/18 in both eyes with correction.
3. Bitemporal hemianopia with considerable sparing in the lower quadrants.
4. Both discs are on the pale side, the right more definitely so.
5. Slight enlargement of sellar cavity.

Diagnosis: Pituitary adenoma. ? Meningioma.

? Aneurysm.

Operation on 31.10.41. Intracapsular extirpation of pituitary adenoma (transfrontal).

Died on 4.11.41 with congestive heart failure and epileptic manifestation (wound was dressed with sulphthiazole).

Histology: /

SERIAL NO. 81 (contd.)

Histology: Cords and compact papillae of chief and foetal cells. Delicate hyaline stroma. Moderate vascularity. Cells seen undergoing hyalinosis and their nuclei fading by karyolysis. Colloid vesicles. Tumour cells seen to undergo granular foamy appearance and to merge into the colloid substance. Mucicarmin stain was negative. E.P.B. stain shows no granules.



SERIAL NO. 82.  
HOSP. NO. C728. (Mr Dott).  
R.C.P. NO. 1219/42.

MRS J.W.

Aged 56 years, menarche started at age of 16 years, stopped at age of 43 years.

Mother migranous. Nothing important to note in the previous illnesses.

Examination on 14.2.42 reveals:

Subjective:

1. Blurring of vision at age of 33 years; progressive deterioration in the last  $1\frac{1}{2}$  years.

Objective:

1. Reminiscent of myxoedema; small thyroid.
2. Slight cyanosis.
3. Diminished visual acuity: Left: 6/9; right: 6/60.
4. Bitemporal hemianopia.
5. Primary optic atrophy on both sides.
6. X-ray appearances of a primarily intrasellar growth.

Operation on 24.2.42. Transfrontal decompression and partial removal of chromophobe adenoma.

Histology: Foetal cell type. Papillary arrangement. Compact papillae in central area. Thin walled capillaries with perivascular hyalinosis. Fine reticulum argyrophyl fibrils around the capillaries (silver). No granules (E.P.B. stain).

SERIAL NO. 83.  
HOSP. NO. C963. (Mr Dott).  
R.C.P. NO. 2636/42.

MRS. B.E.

Aged 38 years, periods began at age of 14 years,  
has one baby.

Admitted on 23.5.42.

C/O:

1. Prolonged lactation for 5 years.
2. Bilateral, supra orbital headache for 10½ weeks.
3. Blurred vision for 7 weeks, ending in total blindness of left eye.

Examination revealed:

1. Definite obsessional tendencies.
2. Complete left anosmia.
3. Diminished visual acuity: Left:  $\frac{1}{2}/6$ ;  
right: 6/9.
4. Temporal hemianopia.
5. Far advanced primary optic atrophy of the left disc; pallor of the temporal half on the right side.
6. Unequality of pupils.
7. Elongated and large pituitary fossa with destruction of the dorsum sellae.

Operation on 1.6.42. Transphenoidal pituitary decompression and biopsy.

Discharged home on 21.7.42.

Histology: /

SERIAL NO. 83 (contd.)

Histology: Foetal cell type; sinusoidal, papillary architecture; delicate hyaline perivascular stroma, vascularity poor; few mitotic figures. No granules (E.P.B. stain).

SERIAL NO. 84.  
HOSP. NO. C1125. (Mr Dott).  
R.C.P. NO. 3674/42 - 3461/44.

E.A.

Female, aged 53 years, married, has one son with congenital syphilis.

Past history of positive W.R.

Hysterectomy for menorrhagia. No X-radiation.

Admitted on 21.7.42.

C/O:

1. Inability to see well on the right side of the page, for 8 weeks.

Examination revealed:

1. Acuity of vision: Left: 6/5 - J.1;  
right: 6/9 - J.4.
2. Complete temporal hemianopia for 2/2000 white object on left side, centrocoecal scotoma for 20 object. Red vision absent. Suggestion of slight upper temporal defect for 2/2000 white object on right side.
3. C.S.F. normal pressure, cellular count and protein content. Negative W.R. and gold colloid test. Blood W.R. and Kahn negative.
4. X-ray shows expansion of sella turcica with notable elongation of the dorsum sellae.

Diagnosis: Chromophobe adenoma.

Operation: Biopsy - partial improvement.

Recurrence of symptoms 2 years later.

Operation /

SERIAL NO. 84 (contd.)

Operation on 12.4.44. Extirpation of cystic pituitary chromophobe adenoma (right frontal route).  
Died on 14.4.44.

Histology: Both biopsies show cords of chief cells and foetal cells. Sinusoidal - papillary pattern. Marked vascularity with haemorrhages. No mitosis. Few piknotic nuclei in second specimen. Stroma delicate. Areas of cholestrol with foreign body giant cells.



SERIAL NO. 85.  
HOSP. NO. C1206(a). (Mr Dott).  
R.C.P. NO. 5194/42.

MISS C.B.

Aged 64 years.

Habitual mannerism of sniffing, subject to  
migraine. Past history of nephritis.

Examined on 27.10.42 for:

1. Deterioration of vision for 3 years.
2. Pain in left side of forehead 3 weeks.

Positive findings are:

1. Restlessness, choreiform movements.
2. Diminished visual acuity: Left: 1/60;  
right: 6/7.5.
3. Temporal hemianopia.
4. Left disc pale with small vessels.
5. Brisk tendon reflexes.
6. X-ray appearances are not such as can  
distinguish with certainty between an  
intrasellar tumour which has expanded  
upwards or a supra sellar tumour.

Diagnosis: Meningioma of the tuberculum sellae.

Operation on 20.11.42. Subtotal extirpation of  
pituitary chromophobe adenoma.

Died on 19.1.43 of cardiac failure.

Histology: Foetal cell type. Characteristic  
pattern. Scanty collagen around thin capillaries.  
Sparse reticulum fibrils (silver impregnation).  
Vascularity poor. E.P.B. stain shows no granules.

SERIAL NO. 86.  
HOSP. NO. C1459. (Mr Dott).  
R.C.P. NO. 5841/43 - 1316/45.

MISS M.C.

Aged 70 years, periods started at age of 15 years and ceased at age of 47 years, associated with migranous attacks.

Chronic rheumatic affection. Chronic gastric ulcer. No other illnesses of importance.

Admitted on 30.12.42.

C/O:

1. Gradual deterioration of vision for 4 months.
2. Polyuria and polydipsia in last month.
3. Headache 1 week ago.
4. Hypersomnolence for 2 days.

Examination revealed:

1. Diminished visual acuity: Right: 6/36; left: 1/60.
2. Fields: Left: a small crossing between  $8^{\circ}$  and  $12^{\circ}$  remains on the nasal side of the fixation point. No ocular vision. Right: complete total hemianopia.
3. Fundi: Left disc is a little paler than the right.
4. Cataract in lenses.
5. Notable decalcification and slight backward displacement of dorsum sellae and posterior clinoids.

Diagnosis: Supra sellar lesion. ? Meningioma.

? Aneurysm.

Operation /

SERIAL NO. 86 (contd.)

Operation on 6.1.43. Subtotal extirpation of pituitary. Chromophobe adenoma (right transfrontal). X-ray treatment.

Discharged on 26.2.43. Recurrence 2 years later. Operation on 27.6.45. Intracapsular removal of recurrent adenoma. Died.

Histology: Chief cells. Diffuse pattern. Delicate trabecular stroma. No marked vascularity. Hyperchromatic nuclei. A number of unusual monster nuclei in the first biopsy. Few mitotic figures.

N.B.: No monster nuclei seen in second biopsy (after operation and X-radiation) and no mitotic figures detected.

SERIAL NO. 87.  
HOSP. NO. C1476. (Mr Dott).  
R.C.P. NO. 6498/43.  
N.P. NO. 3269.

REV. W.M.

Male, 51 years, clergyman.

Operated upon for deviated septum 10 years ago.

Functional loss of voice; otherwise no important past history to note.

Admitted on 8.2.43.

C/O:

1. Deterioration of vision for 8 months.
2. Occasional spasmodic headaches.

Examination revealed bilateral high degree of myopia. X-ray appearances suggestive of an intrasellar type of enlargement of the sella.

Diagnosis: Chromophobe adenoma.

Operation: 17.2.43. Intra capsular extirpation of pituitary chromophobe adenoma.

Discharged improved.

Recurrence 2 years later.

Operation: Transphenoidal partial removal and decompression of pituitary chromophobe adenoma.

Histology: Sheets of chief cells. Diffuse pattern. Well vascularized. Delicate trabecular stroma. No mitosis. Some lymphocytic aggregations.

In /

SERIAL NO. 87 (contd.)

In the second specimen there is an area of coarse collagenous strands. No granules (E.P.B. stain).

SERIAL NO. 88.  
HOSP. NO. C1522. (Mr Dott).  
R.C.P. NO. 7031/43.

G.H.

Male, aged 60 years, miner.

Nothing to note in past illnesses apart from trauma to head in an accident 6 years ago.

Admitted on 9.3.43.

C/O:

1. Failure of vision for 6 months (mainly the the left eye) accompanied with headache. Recent diplopia.
2. No sexual intercourse, emissions or sexual interest for the last 20 years.

Examination revealed:

1. Euphoric. Doubtful mental deterioration.
2. Fields: Bilateral hemianopia with ? scotomata.
3. Visual acuity: Right: J4; left: J20.
4. Left fundus shows early optic atrophy. Right is normal or very early atrophic.
5. X-ray shows enormous globular enlargement of the sella turcica.

Diagnosis: Intra sellar pituitary tumour.

Operation on 17.3.43. Transphenoidal decompression of pituitary adenoma. Biopsy.

Discharged on 9.4.43.

Histology: /



SERIAL NO. 88 (contd.)

Histology: Cords and groups of chief cells together with foetal cells showing perivascular papillary patterns. No marked vascularity. Colloid vesicles visible. Delicate hyaline stroma. No granules (E.P.B. stain).

Admitted on 11.1.43 for acute myeloid leukaemia.

Examination revealed the following positive findings:

History:

1. Insatiable for 7 years with failure to gain weight.
2. Insatiable for 2-10 years.
3. Irritability and puffiness of eyes 3 months ago.
4. Blockage of right nostril for 5-7 months.
5. Increase in size of left and right testis.
6. Irritability.

Examination:

1. Anorexia. Right nostril blocked.
2. Facial puffiness: left; II; right; III.
3. Left nasal polypoid mass of the right eye.
4. Hard, enlarged and scabbing papillomata.
5. Large, enlarged, right testis, left normal.
6. Depressed in first and second III.
7. Enlarged in right testis.

SERIAL NO. 89.  
HOSP. NO. C1644. (Mr Dott).  
R.C.P. NO. 7738/43, 6619/44.

MISS J.M.

Aged 39 years, periods started at the age of 17 years. Mother died of cancer of uterus. She was subject to attacks of headache at the ages of 14-17 years.

Admitted on 26.3.43 for acute aspirin poisoning. Examination revealed the following positive findings:

Subjective:

1. Amenorrhoea for 7 years with fainting turns.
2. Lassitude for 8-10 years.
3. Diplopia and puffiness of eyes 6 months ago.
4. Blockage of right nostril for 8-9 months.
5. Increase in size of feet and fingers.
6. Hirsutism.

Objective:

1. Anosmia. Right nostril.
2. Visual acuity: Left: J1; right: J2.
3. Left nasal hemianopia of the right eye only.
4. Fundi: Actual or subsiding papilleodema.
5. Puffy eyelids; right exophthalmos, fine horizontal nystagmus.
6. Depression in first and second divisions of trigeminal on right side.
7. /

SERIAL NO. 89 (contd.)

7. Slight hypertonus of left lower limb.

8. Gross destruction of the sella and of the whole base of the skull, going forwards with the sphenoid but not into the petrous bone.

Diagnosis: Pituitary chromophobe adenoma.

Operation: 3.5.43. Subtotal extirpation of adenoma.

Discharged on 26.5.43. Recurrence about 1 year later. X-radiation treatment. Then operation on 13.10.44 - right frontal re-exploration chiasmal region.

Followed till 29.8.46 and developed symptoms of ? haemorrhage into the adenoma nodule.

Histology: Sheets of transitional and chief cells. Sinusoidal pattern. Vascularity not marked.

The second biopsy reveals only chief type of cells. Dense hyaline fibrosis.

No alpha granules in sections specifically stained.

SERIAL NO. 90.  
HOSP. NO. C2211. (Mr Dott).  
R.C.P. NO. 839/43 - 1505/43.

MRS M. McB.

Aged 70 years.

Past history of tuberculous adenitis (cervical).  
Recurrent attacks of biliary colic for gall stones.

Examined on 16.11.43 for deterioration of vision  
for 2 years.

X-ray examination revealed a ballooned sella  
turcica.

Operation on 22.12.43. Pituitary transphenoidal  
decompression. Biopsy.

Discharged improved and followed in good  
condition.

Histology: Chief cells. Sinusoidal pattern.  
Moderate vascularity. No colloid or necrosis.  
Specific stain shows no granules.

SERIAL NO. 91.  
HOSP. NO. C2273. (Mr Dott).  
R.C.P. NO. 1500/44, 1794/44.

R.D.T.

Male, aged 47 years, single, musician then clerk.

Past history of piles.

Examined on 20.11.43 for:

1. Enlargement of features and acral parts for 20 years. (Dentist diagnosed prognathous at age of 17 years.)
2. Progressive loss of vision for 3 years.
3. Lack of energy for 3-4 years.

Positive findings are:

1. Acromegalic features.
2. Bitemporal hemianopia.
3. Visual acuity: Right: 6/9; left: 4/60.
4. Left disc shows first sign of atrophy.
5. Slight right nystagmus.
6. Tremors.
7. Enlargement of pituitary fossa.

Diagnosis: Chromophile (eosinophile) adenoma.

Operation on 15.12.43. Transphenoidal decompression and partial removal of pituitary eosinophil adenoma.

X-ray treatment followed.

Discharged on 4.1.44 and followed till 4.12.46.

Histology: /

SERIAL NO. 91 (contd.)

Histology: Mixture of foetal cells and chief cells together with eosinophile cells (N.E.V.O.G. stain). Sinusoidal pattern. No marked vascularity. No mitotic figures. Delicate stroma.



SERIAL NO. 92.  
HOSP. NO. C2292. (Mr Dott).  
R.C.P. NO. 738/43 - 999/43.

MRS J.T.

Aged 43 years. Menstruation began at the age of 14 years, has one child 6 years old.

Past history of ? meningitis and of pneumonia.

Admitted on 29.10.43.

C/O:

1. Undue persistence of milk in the breasts for 2 years after weaning the child.
2. Menstrual troubles and irregularities for 4 years.
3. Deterioration of vision for 2 years.

Examination revealed:

1. Right eye blind; left eye reads J1 (corrected).
2. Temporal hemianopia.
3. Right primary optic atrophy.
4. C.S.F. normal pressure, protein content and cellular count. W.R. negative. Colloid gold reaction negative. Queckenstedt sign negative.
5. X-ray appearances suggest a primarily intrasellar tumour which has enlarged upwards.

Operation on 8.11.43. Intra capsular extirpation of chromophobe pituitary adenoma.

Recovered and followed till 12.7.45.

Histology: /

SERIAL NO. 92 (contd.)

Histology: Foetal cells. Characteristic perithelial pattern. Moderate vascularity. Areas of fresh haemorrhage. Stroma delicate hyaline perivascular collagen.

No granules detected by specific stains.

SERIAL NO. 93.  
HOSP. NO. C2632. (Mr Dott).  
R.C.P. NO. 4069/44 - 4247/44.

MRS E.M.

Aged 51 years, married, 2 children. 2 still  
births.

Appendicectomy done.

Examined on 13.4.44 for:

1. Impaired right eye vision for 2 years.
2. Pain round right eye and right side of nose  
for 6 months.

Positive findings are:

1. Visual acuity: Right eye: single letters  
scotomatosly 6/24 and near vision J16;  
left eye: 6/9 and J4.
2. Bitemporal hemianopia advanced in right with  
a superimposed central scotoma.
3. Fundi: Pallor of discs, more advanced on  
right side.
4. X-ray shows extensive erosion of dorsum  
sellar, but comparatively little  
depression of the sellar floor.

Diagnosis: Pituitary chromophobe adenoma.

Operation on 17.5.44. Intra capsular extir-  
pation of pituitary chromophobe adenoma.

Discharged on 16.6.44.

Followed up till 9.7.44.

Histology: Groups of chief cells. Sinusoidal  
pattern. Stroma delicate and trabecular. Poor  
vascularity. No colloid visible.

SERIAL NO. 94.  
HOSP. NO. C3089. (Mr Dott).  
R.C.P. NO. 7748/44.

J.M.

Male, aged 60 years, single.

History of loss of smell with nasal polyp removed.

Examined on 23.11.44.

C/O:

1. Hypersomnolence for 1 year.
2. Failure of vision within last 3 years.
3. Deafness.

Positive findings are:

1. Dyspituitarism (hair - skin).
2. Bilateral middle ear deafness.
3. Anosmia on either side.
4. Diminished visual acuity: Left: 6/60;  
right: 6/18.
5. Temporal hemianopia.
6. Pale discs on both sides.
7. Deeply hollowed out sellar cavity with  
destruction of dorsum sellae.

Diagnosis: Chromophobe adenoma.

Operation on 8.12.44. Transphenoidal pituitary  
decompression - biopsy.

Recovered - followed till 22.2.45.

Histology: Chief cells. Diffuse type. Moderate  
vascularity. Scanty delicate stroma. No mitosis.  
No granules.

SERIAL NO. 95.  
HOSP. NO. C3318. (Mr Dott).  
R.C.P. NO. 9520/45.

E.H.

Male, aged 49 years, process worker in creamery, then miner, married, started shaving at the age of 21 years. Shaves once a week.

History of gastric ulcer.

Examined on 13.3.45 for:

1. Sexual impotence for last 4 years.
2. Difficulty in reading for 1 month.

Positive findings are:

1. Mid dorsal kyphosis, little scoliosis.
2. Hypopituitarism (Skin - Hair).
3. Visual acuity: Left: 6/60; right: 1/60.
4. Primary optic atrophy.
5. Left complete hemianopia. Right advanced.
6. X-ray appearances suggestive of primary intra sellar tumour. Osteoarthritic changes in vertebral column.

Diagnosis: Chromophobe adenoma.

Operation: Subtotal extirpation of pituitary chromophobe adenoma - right transfrontal approach.

Improved. Discharged on 6.4.45.

Followed till 30.9.46.

Histology: Chief cells. Diffuse pattern.

Delicate trabecular stroma. Vascularity marked with old and fresh haemorrhage. Nospecific granules.

SERIAL NO. 96.  
HOSP. NO. C3723. (Mr Dott).  
R.C.P. NO. 2113/45.

MISS J.W.

Aged 31 years, school teacher. Never menstruated. Left-handed due to birth trauma of right upper limb.

Nothing particular to note in past history.

Examined on 12.7.45 for:

1. Pain in teeth and cheek on left side for 8 years.
2. Dull continuous ache at left lower jaw.
3. Deterioration of vision for 1 year.
4. Increase in weight at the age of 20 years.

Positive findings are:

1. Obesity.
2. Visual acuity: Right: J1 - 6/6; left: hand movement.
3. Fields: Left central scotoma.
4. Fundi: Left primary optic atrophy.
5. Arteriogram shows a pituitary tumour that has come forwards round the carotid artery and displaced it medially.
6. X-ray appearances of an intra sellar expanding lesion.

Diagnosis: Chromophobe adenoma or epidermoid.

Operation on 15.8.45. Intra capsular removal of pituitary adenoma.

Discharged /



SERIAL NO. 96 (contd.)

Discharged on 4.9.45 and followed till 18.10.46.

Histology: Chief cell type. Sinusoidal pattern.  
Moderate vascularity. Some hyalinosis of the stroma.  
No colloid. No mitosis. No granules.

SERIAL NO. 97.  
HOSP. NO. C3863. (Mr Dott).  
R.C.P. NO. 3054/45.

MRS E.P.

Aged 39 years. Menestruation started at age of 15 years and was regular. She has had tuberculous adenitis at the age of 14 years. Two attacks of pleurisy with pneumonia once.

Examination on 4.8.45 revealed the following positive findings:

Subjective:

1. Amenorrhoea for 5 years.
2. Headache for 5 years with deterioration of sight.
3. Exophthalmos for 3 months.

Objective:

1. Diffuse goitre, tremors, bilateral exophthalmos.
2. Visual acuity: Left eye: 6/24 - J16;  
right: 2/60 - J4.
3. Hemianopia.

Treated by thiouracil for the goitre.

Operation:

Histology: Chief cells. Compact diffuse texture centrally and sinusoidal arrangement peripherally.

Moderate vascularity. Scanty hyaline stroma.

Colloid vesicles in tumour.

No granules on specific staining.

SERIAL NO. 98.  
HOSP. NO. C3901. (Mr Dott).  
R.C.P. NO. 2714/45.

MRS M.H.

Aged 52 years, married 10 years ago, had two miscarriages. No living children. Periods began at the age of 15 years and were regular till the age of 47 years.

History of cystic kidney removed.

Examination on 23.8.45 revealed:

Subjective positive findings:

1. Deterioration of vision for  $1\frac{1}{2}$  years.
2. Vomiting and general malaise.

Objective findings are:

1. Visual acuity: Left: 6/12; right: 6/60.
2. Fields normal to confrontation, but perimetry shows clear cut bitemporal hemianopia.
3. X-ray shows enlargement of pituitary fossa.

Diagnosis: Pituitary tumour with haemorrhage.

Operation on 12.9.45. Transphenoidal biopsy and decompression of pituitary adenoma.

Discharged improved and followed till 12.2.47.

Histology: Chief cell type. Sinusoidal pattern.

Very vascular. Scanty delicate stroma.

No granules on specific stain.

SERIAL NO. 99.  
HOSP. NO. C3924. (Mr Dott).  
R.C.P. NO. 3561/45.

J.L.O.

Male, aged 36 years, fireman (previously a clerk),  
married, one child, shaved at the age of 21 years.

"Neurasthenic" brother.

Admitted on 15.10.45 for deterioration of vision  
for 5-6 months.

Examination revealed:

1. Pale optic discs.
2. Generalised briskness of reflexes.
3. Suggestion of very poorly sustained clonus  
at both ankles with bilateral flexar  
Babiniski.
4. Bitemporal hemianopia.
5. Acuity of vision: Left: 6/12; right: 6/9.
6. Balleoned sella turcica with well preserved  
wall.

Diagnosis: Intra sellar chromophobe adenoma.

Operation on 26.10.45. Transphenoidal sellar  
decompression. Biopsy pituitary adenoma.

Discharged on 13.11.45 and followed till 11.46.

Histology: Mixture of chief cells and foetal  
cells. Sinusoidal and papillary pattern. Moderate  
vascularity. Delicate hyaline stroma. No colloid.  
No mitotic figures.

No chromophile granules.

SERIAL NO. 100.  
HOSP. NO. C4149. (Mr Dott).  
R.C.P. NO. 5466/46 - 6011/46.  
N.P. NO. 3079.  
P.M. NO. EHA/621.

MRS A.T.

Aged 61 years, widow for 5 years. Regular menstruation and normal menopause.

Father died of gastrointestinal carcinoma.

Nothing important to note in the past history.

Admitted complaining of three years progressive defects in fields of vision.

Examination revealed:

1. Bilateral primary optic atrophy.
2. Acuity of vision: Right: hand movements; left: J16.
3. A complete right homonymous hemianopia with splitting of the macula.
4. Deep tendon reflexes are brisk.
5. C.S.F. normal pressure, count and protein content.
6. X-ray appearance of a primary intra sellar adenoma which has attained large proportions.

Diagnosis: Pituitary tumour.

Operation on 1.2.46. Transphenoidal decompression, biopsy and limited removal of pituitary chromophobe adenoma.

Died /

SERIAL NO. 100 (contd.)

Died of haemorrhage into remaining tumour mass and cerebral infraction.

Histology: Foetal cells with perivascular arrangement. Chief cells diffusely arranged in the centre together with compacted papillae. Marked vascularity and haemorrhage. Stroma delicate fibrous tissue, fine reticulum. Specific stains show no granules.



SERIAL NO. 101.  
HOSP. NO. C4739. (Mr Dott).  
N.P. NO. 3180.

A.W.

Male, aged 59 years, married, has three children.

Nothing important to note in past history.

Admitted C/O:

1. Blurring of temporal field for 1 year.
2. Loss of libido for 5-6 years.
3. Falling of chest and axillary hair since 4-5 years.

Examination revealed:

1. Visual acuity: Left: J2 but misses temporal words; right: J4 scotoma for individual letters only.
2. Pallor of optic discs.
3. Fields are full to confrontation.
4. Basal metabolic rate: - 9%.
5. X-ray shows a large deep sella with erosion of clinoids.

Diagnosis: Slowly growing type of pituitary adenoma.

Operation on 19.8.46. Transphenoidal decompression and biopsy of chromophobe adenoma.

Histology: Chief cell type. Diffuse pattern with sinusoidal arrangement at the periphery. Marked vascularity. Delicate trabecular stroma but dense hyaline fibrous capsule. No mitosis. No colloid. No granules on specific stains.

SERIAL NO. 102.  
HOSP. NO. C4956. (Mr Dott).  
N.P. NO. 3206.

MISS E.B.

Aged 28 years, single, periods started at the age of 21 years by using hormones, then stopped again.

Nothing important to note in past history.

Admitted on 17.9.46 C/O:

1. Disturbances of menstruation.
2. Attacks of headaches.

Examination revealed:

1. Hypopituitarism (hair). Secondary sexual characters are undeveloped.
2. Acuity of vision: Left: 6/7.5; right: 6/6.
3. Upper right quadrant temporal defect to confrontation.
4. Discs: Right tends to be paler on the nasal half of the disc.
5. Large excavated pituitary fossa.

Diagnosis: Slowly growing chronic type of chromophobe adenoma.

Operation on 20.9.46. Transphenoidal decompression and partial removal of tumour.

Discharged on 4.10.46.

Histology: Chief cells. Diffuse pattern.

Scanty delicate trabecular stroma. Moderate vascularity. No mitosis. No colloid.

SERIAL NO. 103.  
HOSP. NO. C4980. (Mr Dott).  
N.P. NO. 3255.

MRS G.F.

Aged 65 years (darning and burling).

Has had thyrotoxicosis at the age of 24 years and recovered. Normal menopause.

Admitted on 24.10.46 C/O:

1. Disturbances of vision for 6 years.
2. Attacks of headache.

Examination revealed:

1. Visual acuity: Right: 6/24 - J6; left: 6/18 - J4 (corrected).
2. Bitemporal scotomatous hemianopia.
3. Normal fundi.
4. X-ray appearances are more suggestive of a supra sellar tumour than of primarily intra sellar.

Operation on 30.10.46. Intra capsular removal of pituitary chromophobe adenoma.

Discharged on 16.11.46.

Histology: Mainly chief cells with diffuse solid alveolar pattern. Peripherally foetal cells with characteristic arrangement. Scanty delicate stroma. Moderate vascularity. No mitosis. Colloid vesicles visible.

SERIAL NO. 104.  
HOSP. NO. C5114. (Mr Dott).  
N.P. NO. 3273.

P.O.

Male, aged 59 years, night watchman, married,  
8 of a family.

History of duodenal ulcer, perforated appendix  
and peritonitis.

Examined on 5.11.46 for:

1. Loss of libido for 7 years.
2. Increase in weight, polydipsia, polyuria,  
hypersomnolence.
3. Loss of vision.

Positive findings are:

1. Hypopituitarism (obesity).
2. Visual acuity: Left: 6/18; right: blind;  
no light perception.
3. Right primary optic atrophy.
4. Anosmia (right nostril).
5. C.S.F. normal pressure, protein content and  
cellular count. Queckenstedt sign  
negative.

Diagnosis: Pituitary adenoma.

Operation on 14.11.46. Partial removal of  
pituitary adenoma.

Discharged cured.

Histology: /

SERIAL NO. 104 (contd.)

Histology: Mixture of chief cells showing diffuse pattern and foetal cells showing papillary perivascular arrangement. Scanty delicate stroma with hyalinosis. Moderate vascularity. Colloid vesicles present. No granules.

4 years.

Admitted on 11/11/07

- 1. Doubtful reduction of vision
- 2. Occasional headaches for 3 months
- 3. Failure of sight for 2 months

Examination revealed:

- 1. Mild degree of exophthalmos
- 2. Complete left homonymous hemianopsia
- 3. Visual acuity: Right: 4/6 - 20 ft (corrected)
- 4. Small irregular right pupil, not reacting
- 5. Eyelids somewhat protruded and stiff
- 6. Doubtful depression of nasal bridge on left side
- 7. Abnormal and considerable enlargement of optic chiasm on right side
- 8. Gross enlargement of the optic chiasm and destruction of the surrounding structures

Operation on 12/1/07. Left eye removed

Exploration of chiasmatic region

Diagnosis



SERIAL NO. 105.  
HOSP. NO. M334. (Mr Dett).  
R.C.P. NO. 3433/41.  
N.P. NO. 1793.  
P.M. NO. EH/95/A.

S.C.B.

Male, 35 years, upholsterer, then electrician.  
Past history of concomittant squint at the age of  
4 years.

Admitted on 1.9.41 C/O:

1. Doubtful reduction of libido for 1 year.
2. Occasional headaches for 3 months.
3. Failure of sight for 2 months.

Examination revealed:

1. Mild degree of euphoria.
2. Complete left homonymous hemianopia.
3. Visual acuity: Right: 6/12 - J4; left: 6/18  
- J4 (corrected).
4. Small irregular right pupil, not reacting.
5. Obvious concomittant convergent strabismus.
6. Doubtful depression of corneal reflexes on  
left side.
7. Abdominal and cremasteric reflexes are more  
on right side.
8. Gross enlargement of the sella turcica with  
destruction of the surrounding parts of  
bone at the base of the skull.

Operation on 12.9.41. Left transfrontal  
exploration of chiasmal region.

Died /



SERIAL NO. 105 (contd.)

Died on 16.9.41 in a status epilepticus.

Histology: Cords of chief cells. Sinusoidal pattern with papilliferous projections. Marked vascularity, haemorrhage and thrombosis. Hyaline fibrous stroma. No colloid. No mitosis.

SERIAL NO. 106.  
HOSP. NO. M550. (Mr Dott).  
R.C.P. NO. 2137/42.

B.M.

Male, 24 years of age, single, assistant in cardboard factory, conscripted in Navy.

History of tuberculosis in the family.

Past history of nocturnal aneurisis. Fainted once at the age of 17 years.

Examination on 11.3.42 for:

1. Headache for 18 months.
2. Epistaxis.
3. Attacks of fainting for 13 months.

Positive signs are:

1. Optic discs show some oedema and pallor.
2. Visual fields restricted for green and red.
3. Trace of hemianopia.
4. C.S.F. 10 cells/cmm., W.R. -, proteins 30 mgm%.
5. Greatly expanded sella turcica by an expanding lesion primarily intra sellar.

Operation on 18.3.42. Right transfrontal osteoplastic flap. Exploration of chiasm postponed.

On 1.5.42 ventriculogram. Intra capsular removal of small pituitary adenoma.

Discharged on 13.7.42.

Followed /

SERIAL NO. 106 (contd.)

Followed till 13.9.46.

Histology: Chief cell type. Diffuse pattern.  
Vascularity not marked. Areas of haemorrhage and of  
fibrosis. No colloid. No mitosis.

SERIAL NO. 107.  
HOSP. NO. ML282. (Mr Dott).  
R.C.P. NO. 3442/44 - 3652/44.

P.F.S.

Male, aged 34 years, single, in Pioneer Corps.  
Past history of jaundice, piles and malaria (treated  
with quinine). Deafness since then.

Admitted on 24.3.44 C/O:

1. Deterioration of vision for 1 year.
2. Lassitude and loss of memory.
3. Frontal headache.

Examination revealed:

1. Bears resemblance to acromegalic group  
(large heavy supra orbital ridges).
2. Moderate degree of optic atrophy on right  
side.
3. Bitemporal hemianopia with central scotoma  
in left eye.
4. X-ray shows globular enlargement of sella  
turcica characteristic of an expanding  
lesion.

Diagnosis: Transitional eosinophil adenoma.

Operation on 7.4.44. Extirpation of pituitary  
adenoma. Right transfrontal procedure.

Discharged on 11.6.44.

Histology: Mixture of chief, foetal and  
transitional cells. Diffuse pattern in centre and  
papillary /

SERIAL NO. 107 (contd.)

papillary arrangement in the periphery. Poor  
vascularity. Scanty delicate trabecular stroma.  
Colloid present.

N.E.V.O.G. stain does not show cells with the  
alpha granules.

SERIAL NO. 108.  
HOSP. NO. C3130. (Mr Dott).  
R.C.P. NO. 2797/45.  
N.P. NO. 3004.

MISS G.R.

Aged 43 years, clerkess. Has had pulmonary tuberculosis. Suffered from skin disease.

Examined on 18.11.44 for:

1. Florid complexion and hirsuties first noted 7-8 months ago.
2. Headache.
3. Amenorrhoea for 11 months.
4. Pigmentation in exposed skin of neck and in areolae for 3-4 years.

Positive findings are:

1. Typical appearance of Cushing's syndrome (B.P. 200/134).
2. Moderately enlarged thyroid - no thyrotoxicosis.
3. Malar cyanosis, marked bilateral chemosis.
4. Serpigenous purplish skin eruption over feet, ankles and lower quarters.
5. Normal fundi, but narrow retinal vessels.
6. Blood picture: Hb. 110%. RBC's 5500000.
7. Urine: Pregnandiol none. 17 ketosteroids low (excludes adrenal hyperplasia or tumour).
8. X-ray shows no abnormality in size of sella turcica.

Treatment: /



SERIAL NO. 108 (contd.)

Treatment: Deep X-ray therapy.

Operation: Implantation of 3 radon seeds into pituitary gland. No evidence of tumefaction of the pituitary gland.

N.B.: X-radiation of the pituitary failed to cause any material alteration in the syndrome and surgical exposure of the pituitary gland revealed a normal appearing gland with some necrotic changes.

Histology: Completely necrotic tissue of pituitary pattern. No leucocytic infiltration.

N.B.: This case is excluded, since there is no material evidence of a pituitary adenoma.

SERIAL NO. 109.  
HOSP. NO. M66. (Mr Dott).  
N.P. NO. 1601.

L.F.

Male, aet 27 years. Sergeant.

Admitted on 4.11.40 with the following history:

1. Increase in weight in last 2 years.
2. Polydipsia one month. Polyuria recently.
3. Right sided headache for one week.

Examination revealed:

1. Acromegalic features of about 10 years' standing.
2. Sluggish reflexes.
3. Some restriction of visual field in left eye.
4. X-ray - marked enlargement of sella turcica and destruction of left anterior clinoid.

On 4.11.40 suddenly developed severe headache, complete loss of vision in the left eye, vomiting, left pupil lost reactions.

Early papilloedema of both discs.

Lumbar puncture; partial relief.

Pulse, temperature and respirations began to rise.

Died on 5.11.40.

P.M. "showed an enormous pituitary adenoma into which haemorrhage had occurred and which also appeared to have bled upwards into the third ventricle".

Histology: /

SERIAL NO. 109 (contd.)

Histology: Transitional cells arranged in a perivascular manner around the blood vessels.

The cells are polychromic with the E.P.B. stain.

SERIAL NO. 110.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 235/36.

H.J.F.

Male, aet 21 years, single.

C/O:

1. Acromegalic features for 3 years with headache.
2. Failure of vision for about 6 months.

Examination revealed:

1. Right inferior basal quadrantopia.
2. Right primary optic atrophy.
3. Expanded sella turcica.

X-ray treatment has not influenced condition.

Operation on 5.10.36.

Histology: Transitional and eosinophil cells.

Multinucleated cells present. Evidence of necrosis and pyknotic nuclei.

Stroma very delicate and scanty.

Haemorrhage into tumour.

SERIAL NO. 111.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 721/36 - 886/36.

E.H.

Female, aet 38 years, married.

C/O:

1. Amenorrhoea for 3 years.
2. Progressive failure of eye sight since then.

Examination revealed:

1. Bitemporal hemianopia and optic atrophy.
2. X-ray appearances of expanded sella.

Operative treatment.

Histology: Chief cells in the centre with diffuse arrangement. Foetal cells in the periphery with the perivascular arrangement.

Poor vascularity.

Stroma is delicate and scanty. Slight perivascular hyalinosis in peripheral part.

No colloid. No haemorrhage.

SERIAL NO. 112.  
HOSP. NO. (Mr. Pattison).  
R.C.P. NO. 932/36.

J.T.C.

Male, aged 57 years.

C/O: Failing sight for  $2\frac{1}{2}$  years.

Bitemporal hemianopia was detected on examination.

Sella turcica is expanded.

Operation on 10.12.36.

Histology: Diffuse, compact, chief cells centrally and papillary, foetal cells in the periphery.

Vascularity not marked.

Stroma consists of delicate strands of collagen.

Colloid cysts visible.



SERIAL NO. 113.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 7451/36.

L.C.

Female, aet 32 years.

Examination revealed the following positive signs:

1. Fugitive acromegaly for 7 years.
2. Headache without visual disturbance.
3. Sudden hemiplegia 3 months before operation with right oculomotor paralysis.
4. Downward excavation of sella turcica.

Exploration showed tumour presenting entirely backwards.

Died from haemorrhage into cystic extension of tumour beneath the pons.

Histology: Mixture of chief, transitional and few eosinophil cells.

Multinucleated forms are encountered.

Stroma is scanty and delicate.

Haemorrhage.

SERIAL NO. 114.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 9917/36.

S.H.

Female, 19 years old, single. Menestruation  
normal.

Examination revealed the following positive  
findings:

1. Gigantism for 3 years.
2. Recent failure of eye sight.
3. Bilateral primary atrophy with general  
constriction of fields.

No hemianopia.

Operation: Total removal of supra sellar tumour.

Histology: Mixture of transitional and eosinophil  
cells.

Delicate stroma; poor vascularity.

No colloid nor haemorrhage.

SERIAL NO. 115.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 3130/37 - 3248/37.

H.G.

Female, aet 58 years, married.

Examination presents the following positive findings:

1. Acromegalic external features coming 15 years ago.
2. Progressive visual failure throughout duration of illness.
3. Optic atrophy.
4. Bitemporal hemianopia.

Diagnosed as: Eosinophile adenoma.

Operation.

Histology: Transitional cells and a fair number of eosinophile cells showing peripheral alpha granules. Scanty delicate trabecular stroma. Few mitotic figures. Occasional multinucleated cells. Colloid cysts visible.

SERIAL NO. 116.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 4390/37.

J.J.G.

Male, aet 43 years, married.

Typically acromegalic for the past 17 years with early chiasmal compression.

Operation.

Died from broncho pneumonia.

Histology: Alveoli of large eosinophil cells.

Stroma forms laculi surrounding groups of cells.

Poor vascularity. No haemorrhage.

SERIAL NO. 117.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 5548/38.

C.J.

Male, aet 34 years, single.

Shows acromegalic features and headache for  
7 years.

Rapid failure of vision for 5 months.

Operation with excellent recovery.

Histology: Transitional cells. Diffuse pattern.  
Few eosinophil cells. Multinucleated forms.  
Delicate scanty stroma. Haemorrhage. No colloid.

SERIAL NO. 118.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 6190/38 - 6194/38.

R.M.

Male, 28 years, single.

Examination reveals the following findings:

1. Increasing vascular hypertension and attacks of haematuria since the age of 14.
2. Striations of skin of legs and thighs.
3. Blood pressure 220/150.
4. Blood picture:

Count: R.B.C's 5,860,000. H.b.: 106%.  
W.B.C's 7,700.

Urea: 26 mgm/100 cc serum.

Calcium: 10 mgm %.

Sugar curve: Diabetic type.

5. Basal metabolic rate - 6%.
6. General X-ray evidence of osseous decalcification and old fractures of ribs.

Operation on 24.3.38. Implantation of radon seeds into pituitary.

Died on 29.3.38 of haemolytic streptococcal infection of throat and neck.

Histology: Fragments of basophil adenoma.

Haemorrhagic necrosis in pituitary.

Crookes' degeneration in basophiles of pituitary but none in tumour.



SERIAL NO. 119.  
HOSP. NO. (MR Pattison).  
R.C.P. NO. 6901/38.

W.M.

Male, aet 43 years, married.

Blindness of rapid onset 6 weeks ago with increasing obesity and general evidence of lack of pituitary function.

Entire history within past 6 months.

X-ray shows complete destruction of pituitary fossa.

Operation.

Histology: Foetal type. Papillary at the periphery and compact in centre.

Colloid present. Delicate hyaline stroma surrounding the blood vessels. No haemorrhage or mitosis.

SERIAL NO. 120.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 8616/38.

N.R.

Female, 29 years, single.

Examination shows:

1. Absolute amenorrhoea for 15 years.
2. Failure of vision within a year.
3. Left homonymous hemianopia with early optic atrophy.
4. Very slight fugitive acromegaly.

Diagnosis: ? mixed or chromophobe adenoma.

Operation: 19.12.38.

Histology: Foetal cell type. Papillary arrangement. Scanty delicate stroma. No marked vascularity. No colloid.

SERIAL NO. 121.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 9561/39.

G.D.

Male, 26 years old, single.

C/O: Loss of left half and part of right half of field of vision of left eye.

Pain in ophthalmic division of 5th nerve above left eye.

Operation.

Histology: Biopsy material is scanty. Still it shows foetal cells with poor vascularity.

Possibility of a mixture of cells cannot be excluded.

SERIAL NO. 122.

HOSP. NO. (Mr Pattison).

R.C.P. NO. 6500/35, 9136/36, 5497/38, 5920/38.

L.H.

Male, 27 years of age, married.

History of illness is said to be 8 years.

Operation on 10.4.33.

Recurrence: Operation on 21.3.38.

Histology: Chief cell type. Diffuse pattern.

Scanty stroma. Moderate vascularity. Haemorrhage  
(old and fresh). Psammoma - like bodies in the  
capsule.

SERIAL NO. 123.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 6498/35 - 8384/36.

C.G.

Female. Cushing's syndrome.

History not available.

Histology: Adenoma is well-circumscribed; encapsulated. Component cells are foetal with the typical perivascular arrangement. Some transitional basophiles. Some show actual granules.

There is evidence of necrosis. No marked vascularity. Delicate stroma.

Pituitary tissue surrounding is compressed. Basophil cells show Crooke's degeneration.

SERIAL NO. 124.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 6499/35.

J.K.

Female.

History not available.

Histology: Diffuse pattern of chief cell type.

Delicate stroma. No marked vascularity.



SERIAL NO. 125.  
HOSP. NO. (Dr S. Bell).  
R.C.P. NO. 2103/39.

J.K.

Female, aet 44 years, single.

History of amenorrhoea for 22 years.

Increasing adiposity.

Temporal hemianopia (left eye for 1 year).

Diagnosis: Pituitary adenoma.

Histology: Chief cell type. Diffuse cell type.

Marked vascularity with haemorrhage. Stroma moderately dense and fibrous at the periphery and delicate trabecular in the centre.

Little mitosis.

SERIAL NO. 126.

HOSP. NO. (Dr Pattello, Dumfriesshire Royal  
Infirmary).

R.C.P. NO. 7336/44.

G.W.

Male, 43 years.

Admitted comatose.

Previous history of headaches. Dimness of  
vision.

Histology: Foetal cell type. Poor vascularity.  
No haemorrhage or mitosis. Stroma: perivascular  
delicate connective tissue.

SERIAL NO. 127.  
HOSP. NO. (Dr McKenzie).  
N.P. NO. 322.  
P.M. NO. RIE/646/35.

J.G.

Male, 47 years of age.

Suffered from ? partial Cushing's syndrome.

Plethora. Increased basal metabolic rate. High blood pressure. Scoliosis.

Histology: Transitional basophilic. Diffuse type. Some perivascular arrangement around capillaries. Few cells are only basophilic.

The tumour is lying subdurally, at the lower posterior part of pars anterior.

Crooke's degeneration evident in the pituitary.

SERIAL NO. 128.  
HOSP. NO.  
N.P. NO. 447.  
P.M. NO. RIE/303/36.

MISS J. McV.

Female, 58 years of age.

History not available.

Histology: Chief cell type. Diffuse pattern.

Delicate scanty stroma. Some necrosis. No mitosis.  
No colloid.

By the naked eye the tumour extended to the sphenoid and right cavernous sinus through which it has extended to the posterior fossa.

SERIAL NO. 129.

HOSP. NO. (Dr Roberts, Leicester).

N.P. NO. 507.

M. (Negress).

Female, aet 35 years.

History not available.

Histology: Mainly transitional cells with some chromophobes and scanty basophiles.

No marked vascularity.

Crooke's degeneration in the gland.

Hyperplastic positive fuchsinophil reaction in adrenals.

SERIAL NO. 130.  
HOSP. NO. (Dr Dryerre).  
N.P. NO. 646.

J. McB.

Male, aet 34 years.

Acromegalic.

Histology: Chief and transitional cells. Some eosinophile cells. Scanty stroma. Vascularity is poor. Irregular arrangement.



SERIAL NO. 131.  
HOSP. NO. (M.H.A.).  
N.P. NO. 665.

No history available.

Histology: Chief cells. Diffuse pattern.

Delicate scanty stroma. Vasculature not marked.

Pituitary tissue atrophied.

N.B.: Naked eye, tumour was 3 x 3 x 2 cm  
projecting and indenting the base of the third  
ventricle.

SERIAL NO. 132.  
HOSP. NO. (Dr. Hill).  
N.P. NO. 897.  
P.M. NO. RIE/85/38.

H.C.

Male, aet 53 years.

Acromegalic since Great War of 1914.

No eye trouble.

Histology: Transitional and eosinophil cells.

Scanty stroma. Well encapsulated. No marked  
vascularity. No regularity of arrangement.

SERIAL NO. 133.

HOSP. NO. (Stirling Mental Hospital - Dr. Hagedon).

N.P. NO. 937.

J.G.

Male, aet 69 years, died of generalised cortical gliosis.

Histology: Chief cells. Diffuse pattern.

Scanty trabecular stroma. Vasculature poor.

N.B.: Naked eye, the adenoma was 6 times the normal hypophysis.

SERIAL NO. 134.  
HOSP. NO. (Dr. Taylor).  
R.C.P. NO. 6575/28.

History not available.

Histology: Chief and foetal cells. Diffuse  
compact in part and papillary in others. Moderate  
vascularity. Scanty trabecular stroma.

SERIAL NO. 135.  
HOSP. NO.  
R.C.P. NO. 2232/31.

Female.

History not available.

Histology: Chief cells. Diffuse pattern.

No marked vascularity. Delicate stroma.

SERIAL No. 136.  
HOSP. No. 1804 (Mr. DOTT)  
N.P. No. 393  
P.M. No. RIE/149/36.

M.R.

Female. 35 Years.

Case of Virilism and high blood pressure.

Clinical data unavailable.

P.M. : Hypophysis is of normal size. Nodule on antero-inferior aspect, small and reddish (4x3x3mm)

Histology : Basophile cells.

Vascularity marked.

Crooke's degeneration in basophile cells.

N.B. Adrenals show thick cortex but no acid fuchsin reaction.



SECTION 1.  
NO. 123. (1912)  
D.C. No. 10-10  
W.P. No. 101  
H.S. No. 10000000

1.5.  
Male, 37 years of age, married for 15 years.  
1 child. Wife has no other children for 15 years.  
Married in 1900.

1. Interposition of tumor, size of 2 cm.
2. Ovarian tumor.

II. MALIGNANT.

3. Invasive
4. Invasive
5. Invasive
6. Invasive

A. Primary.

B. Secondary.

7. Invasive
8. Invasive
9. Invasive
10. Invasive

Diagnosis: Invasive carcinoma of the  
ovary.  
Operation:

SERIAL NO. 1.  
HOSP. NO. 1951. (Mr Dott).  
R.C.P. NO. 4925/40.  
N.P. NO. 1804.  
P.M. NO. Longmore 41.

H.F.

Male, 37 years of age, married for 15 years,  
1 child. Wife has no other children for 12 years.

Examined on 21.8.40 for:

1. Deterioration of vision, right eye for 4 months.
2. Occasional headaches.
3. Polyuria for 4 months.
4. Insomnia for 4 months.
5. Diminished sexual desire for 10 weeks.
6. Feeling of hunger for 3 months.
7. Pains in shoulder and swelling of face 4 months ago.

Positive findings are:

1. Hypopituitarism (stature).
2. Visual acuity: Right eye: hand movements;  
left eye: 6/24 - J2.
3. Left temporal hemianopia (incomplete).
4. X-ray shows expansion of sella turcica.  
Decalcified walls. Thin and backward-  
displaced sorsum.

Diagnosis: Intra sellar progressive expanding  
lesion.

Operation /

SERIAL NO. 1 (contd.)

Operation on 3.9.40. Subtotal extirpation,  
supra sellar meningioma.

X-radiation.

Discharged. Recurrence on 4.1.41.

Died on 7.10.41.

P.M.: Tumour has grown up into hypothalamic  
region, frontal regions, right temporal region, right  
pars and right cerebral peduncle. Through choroid  
fissure to right lateral ventricle.

Histology: Small solid alveolar groups of uniform  
tumour cells separated by fibrous trabeculae.

Cytoplasm is non-granular. Mitotic figures are  
evident. Nuclei hyperchromatic and rather elongated.  
Evidence of necrosis.

Necropsy material shows tumour cells inside a  
large artery.

Metastases in liver (recently formed) surrounded  
by false capsule.

SERIAL NO. 2.  
HOSP. NO. 703. (Mr Dott).  
R.C.P. NO. 267/33, 353/33, 398/33.

MR. W.

Aet 57 years. Contractor.

Past illnesses: Nothing important to note.

Examined on 13.10.33 for:

1. Polyuria (diabetes insipidus), polydipsia for 4 months.
2. Headaches for 2 months.
3. Papilloedema, noticed on medical examination.
4. Tinnitus for 1 month.

Positive findings are:

1. Average stature, slight emaciation, pale greyish complexion.
2. No gross visual defect.
3. Definite papilloedema, few haemorrhages on left side suggestive of increased intracranial pressure.
4. Positive W.R. in blood. C.S.F. Colloid gold 00010,00000. W.R. moderately strong, proteins 100 mgm%, cells 1/cmm. Slight trace of globulin.
5. Marked degree of decalcification of basiphosphoid. Pineal calcification.

Diagnosis: ? Basal meningo encephalitis.

Operation: 22.10.33. Bilateral subtemporal decompression. Some degree of hydrocephalus.

Died. No P.M. recorded.

Histology: /

SERIAL NO. 2 (contd.)

Histology: Appearances are those of a papillary carcinoma of a mucus secreting organ. Metastases in brain tissue.

History of tubercular in the family.

Previous illnesses: Rheumatism, from childhood to the age between twenty and thirty.

Examination on 12.11.35 revealed the following positive findings:

Subjective: Determination of vision for 32 months.

Objective:

1. Dysmetropia (left - skin - shell).

2. Visual acuity: Left: 1/10, 6/30;  
right: 1/10, 6/30.

3. Bitemporal hemianopsia, absent.

4. Normal description of the walls of the sella turcica.

Diagnosis: Primary disease: pharyngeal carcinoma.

Operative: Transnasal decompression.

Partial removal of primary disease on 9.12.35.

Postoperative course.

Discharged on 1.2.36.

Followed /

SERIAL NO. 3.  
HOSP. NO. 1636. (Mr Dott).  
R.C.P. NO. 8529/38.

P. McL.

Male, aet 62 years.

History of tuberculosis in the family.

Previous illnesses: Haemorrhage from stomach at the age between twenty and thirty.

Examination on 18.11.38 revealed the following positive findings:

Subjective: Deterioration of vision for 12 months.

Objective:

1. Dyspituitarism (hair - skin - obesity).
2. Visual acuity: Left: J10, 6/24;  
right: J16, 3/36.
3. Bitemporal hemianopia, clear cut.
4. Enormous destruction of the whole of the sella turcica.

Diagnosis: Pituitary adenoma: pharyngeal endothelioma.

Operation: Transphenoidal decompression.

Partial removal pituitary adenoma on 9.12.38.

X-radiation course.

Discharged on 1.2.39.

Followed /



SERIAL NO. 3 (contd.)

Followed up till 10.2.46 in good condition.

Died on 28.3.47 with what suggests a left carotid artery thrombosis (? recurrence or ? X-radiation).

Histology: Cords of large cells, with rather elongated nuclei, hyperchromatosis. Sparse mitosis. Vascularity more or less sinusoidal.

N.B.: No P.M. recorded.

SERIAL NO. 1.  
ROST. NO. 118. (1st Part).  
R.C.P. NO. 211/22.

Case 1,3.

Female, 27 years. Unconventional type of eye  
at 13 years. Two children (children, 10 years old).  
No pregnancies in last 10 years and no intention to  
prevent this. Subject is 27 years old.

Examined 1922

1. "Billow's disease" during last 10 years with  
occasional vomit.

2. Irregular menstruation with occasional  
amenorrhoea for 2 years.

3. Headache

### III. CRANIOPHARYNGIOMA.

4. Ocular exophthalmos

5. Shooting pains above both eyes and in the left  
side of head sometimes as far as the back  
of the neck, for 2 months.

6. Deformation of vision for 2 months.

Positive findings are:

1. Definite left exophthalmos.

2. Slight relative right exophthalmos.

3. Visual acuity: Right, poorer than left with  
uncertainty at one point. Left, poor light  
perception.

4. Temporal tenderness with relative preservation  
of upper quadrants on right side.

5. Marked degree of primary optic atrophy.

6. Some sensory loss and sustained to touch.

7. Definite state of malnutrition which has  
fully varied.

Diagnosis: /

SERIAL NO. 1.  
HOSP. NO. 116. (Mr Dott).  
R.C.P. NO. 6214/28.

MRS A.H.

Female, aet 44 years. Menstruation began at age of 13 years. Two children (younger, 10 years old). No pregnancies in last 10 years and no intention to prevent this. Subject to headaches for 27 years.

Examined for:

1. "Bilious attacks" during past 10 years with occasional vomit.
2. Irregular menstruation with incomplete amenorrhoea for 3 years.
3. Rapid access of adiposity.
4. Unduly easily fatigued for 3 years.
5. Shooting pains above left eye and along left side of head sometimes as far as the back of the neck, for 6 months.
6. Deterioration of vision for 3 months.

Positive findings are:

1. Definite left exophthalmos.
2. Slight relative right anosmia.
3. Visual acuity: Right, counts fingers with uncertainty at one foot; left, bare light perception.
4. Temporal hemianopia with relative preservation of upper quadrants on right side.
5. Marked degree of primary optic atrophy.
6. Some memory loss and emotional instability.
7. Definite flake of calcification within the sella turcica.

Diagnosis: /

SERIAL NO. 1 (contd.)

HOSP. NO. 145. (Mr. Dutt).  
M.S. 145.

Diagnosis: Supra sellar craniopharyngeal cystic tumour.

Operation on 12.9.28. Radical removal.

Histology: Squamoid epithelium. Adamantinoma appearances. Keratinisation. Foreign body giant cells. Cholestral. Calcification.

3. Size growth in early years.

Examination reveals the following positive

findings:

1. Very numerous small keratin-filled cysts.

2. Keratinised on surface and the appearance of

progressive and accompanied with calcification.

Operation on 21.9.28. Right hemispheric

approach. Tumour had completely gone. No residual development. Absence.

Histology: Adamantinoma type. Squamoid epithelium.

keratinisation. Foreign body giant cells. Cholestral.

Early calcification.

Keratin are filled with keratin and the surface is

degenerating epithelium which contains keratin. The tumour is deeply stained with eosin.

SERIAL NO. 2.  
HOSP. NO. 145. (Mr Dott).  
R.C.P. NO. 7486/29.

MISS I.G.

Aet 12 $\frac{1}{2}$  years.

Admitted to R.I.E. in 1924 C/O:

1. Headache, vomiting, giddiness.
2. Diplopia and squint for 9 months.
3. Slow growth in last 5-6 years.

Examination showed the following positive findings:

1. Very pronounced optic neuritis on both sides.

Readmitted on 9.1.29 and the symptoms were progressive and accompanied with polyuria.

Operation on 24.3.29. Right transfrontal approach. Tumour had obviously been of intra sellar development. Adherent.

Histology: Adamantinomatous. Basal cell layers. Whorls. Stellate cells. Marked keratinisation. Early calcification.

Pearls are definitely seen to be formed of degenerating epithelium which swells up, and becomes deeply stained with eosin.

Histology: Adamantinomatous.

Myxomatous with keratinous masses.

To /

SERIAL NO. 3.  
HOSP. NO. 247. (Mr Dott).  
R.C.P. NO. 951/30.

E.B.

Female, aet 19 years.

Examined for:

1. Irregular scanty menstruation for 15 months that ceased altogether 7 months ago.
2. Headaches for 6 months.
3. Somnolence for 6 months.
4. Failure of vision for 6 months.
5. Diplopia 3 months ago.
6. Gradual loss of weight over a period of 3 years.

Positive findings are:

1. Visual acuity: Right, 6/36; left, 6/12.
2. Bitemporal hemianopia with small central sparing on left side.
3. Discs: Right, slightly pale; left, normal.
4. Deeply excavated and widened sella with marked thinning of dorsum sellar and posterior clinoids. No calcification.

Diagnosis: Craniopharyngioma.

Operation: Complete removal of craniopharyngeal cyst. Right transfrontal exposure.

Discharged improved.

Histology: Adamantinomatous in parts. One part squamoid with prickle cells.

No /



SERIAL NO. 3 (contd.)

No keratinisation. Very vascular. No calcification. Wall consists of fibrous tissue with strands of pituitary remnants.

Examination revealed the following positive findings:

Subjective:

1. 24 years old female, history of acute inflammation. She reports a 1 year history of symptoms.
2. History of 1 year.
3. History of 1 year.

Objective:

1. Right vision, normal.
2. Left vision, normal.
3. ...
4. ...
5. ...

Diagnosis: ...

Operation: ...

exposure. ...

Discussion: ...

Died at age of 24.

Histology: ...

SERIAL NO. 4.  
HOSP. NO. 252. (Mr Dott).  
R.C.P. NO. 1050/30.

J.W.

Female, 32 years.

Examination revealed the following positive findings:

Subjective:

1.  $2\frac{1}{2}$  years ago sudden cessation of menstruation. Two normal periods recurred 1 year ago, but since then again complete amenorrhoea.
2. Headache for 1 year. No faintness nor vomiting.
3. Failure of vision for 1 year.

Objective:

1. Right vision, barely hand movements.  
Left vision, 6/9. Fields: Right, light perception in upper nasal quadrant and ? also in upper temporal. Left, clear cut temporal hemianopia with some encroachment on lower nasal quadrant.  
Discs: Right, early primary atrophy.
2. X-ray shows perfectly normal sella.  
No superimposed calcification.

Diagnosis: Craniopharyngioma.

Operation on 2.7.30. Right transfrontal exposure. Incomplete removal of solid craniopharyngioma.

Discharged on 21.7.30.

Died at home on 10.6.31.

Histology: /

SERIAL NO. 4 (contd.)

Histology: Adamantinomatous. Differentiated squamous epithelium with prickle cells in one area. Myxomatous stroma. Anastamosing branches (plexiform in appearance). No calcification.

SERIAL NO. 5.  
HOSP. NO. 256. (Mr Dott).  
R.C.P. NO. 1084/30 - 1114/30.

J.W.

Male, aet 15 years, school boy.

Examination on 8.7.30 revealed:

Subjective findings:

1. Practically no increased stature in last 5 years. Slight gain in weight in this period but no sudden accession adiposity.
2. 3 years ago: Headache. Most intense left frontal.
3. 3 years ago: Polyuria and polydipsia lasting for 3 months. No recurrence.
4. Failure of vision  $2\frac{1}{2}$  years ago.
5. Tendency of left eye to deviate outwards for 2 years.

Objective findings:

1. X-ray shows widely distended sella turcica with intact clinoid processes. Flakes of calcification above.
2. Diminished visual acuity: (Right: 6/9; left: 6/18).
3. Bitemporal hemianopia.
4. Well marked primary optic atrophy left.
5. Outward strabismus left eye.
6. Hypopituitarism - genital infantilism.

Diagnosis: Craniopharyngioma.

Operation on 11.7.30. Right transfrontal exposure. Complete removal of cystic craniopharyngioma.

Discharged. /

SERIAL NO. 5 (contd.)

Discharged. Followed till 23.7.35. Recurrent acute attacks of increased intra cranial pressure. Suboccipital decompression done. Discharged.

Died at home on 27.10.37.

Histology: Stratified epithelium. Cholestral crystals with giant cells. Pituitary remnants and plasma cells in capsule.

SERIAL NO. 6.  
HOSP. NO. 293.  
R.C.P. NO. 1912/30.

D.W.

Male, aet 11 years.

Nothing important to note in past history.

Examination on 28.10.30 revealed the following positive findings:

Subjective:

1. Sudden onset of headache, vomiting and drowsiness 6 years ago. This attack lasted one week. Recurrent 3 years ago. Less severe attacks since then.
2. Sudden loss of sight following the headache. Partial improvement on left side.
3. Anorexia for 6 years.
4. Cessation of growth for 5 years.
5. Polydipsia and polyuria 4 years ago. Ceased.
6. Somnolence - ceased.
7. Hallucinations of smell.

Objective:

1. Distension and erosion of sella turcica with flakes of calcification.
2. Right eye totally blind; left, 6/60. Temporal hemianopia in left eye. Bilateral primary optic atrophy.
3. Hypopituitarism.

Diagnosis: Supra sellar craniopharyngioma.

Operation on 7.11.30.

Died /



SERIAL NO. 6 (contd.)

Died on 26.11.30.

P.M. showed acute cerebral softening in the anterior basal region.

Histology: Squamoid. Small area adamantinomatous. Pearls with giant cells. Cholesterol. Oedematous stroma. Lipoid macrophages. Dense capsule with lymphocytes.

Positive findings are:

1. Dysplastic changes in the brain.
2. Visceral still tends to be normal.
3. High value of some cells in the brain.
4. Slight degeneration of some cells.

Operative treatment:

Histology: Adamantinomatous - squamoid.

Keratinisation. Delimited. Squamous cell

formation. Cholesterol. Lipoid macrophages.

Cholesterol. Giant cells.

Neuronal degeneration. High value of some cells.

with cellular changes. Some cells in the brain.

Pituitary gland. Some cells in the brain.

SERIAL NO. 7.  
HOSP. NO. 374. (Mr Dott).  
R.C.P. NO. 3509/31 - 3573/31.

J.K.

Aet 25 years, male, single.

Nothing important to note in past history.

Examined on 11.6.31 for:

1. Attacks of headaches for 3-4 months.
2. Deterioration of vision for 6-7 months.

Positive findings are:

1. Dyspituitarism (hair - skin).
2. Vision: Still reads news-print.
3. Slight pallor of both discs, myopic, ovoid discs.
4. Slight depression of right corneal reflex.

Operative treatment.

Histology: Adamantinomatous - epidermoid.

Keratinisation. Calcification. Imperfect bone formation. Oedematous myxomatous stroma.

Cholestrol. Giant cells.

Remnants of pituitary tissue and of lymphocytes with actual germinal centres are seen in the wall.

Pituitary tissue shows colloid vesicles too.

SERIAL NO. 8.  
HOSP. NO. 444. (Mr Dott).  
R.C.P. NO. 4746/31.

J.M.

Male, aet 33 years.

Examined on 3.11.31 C/O:

1. Headaches about the age of 14 years.  
Recurrent attacks, later associated with vomiting and diplopia.
2. A left homonymous hemianopia and paracentral scotoma affecting the lower left quadrant was detected on medical examination.
3. X-ray is said to show erosion of the posterior clinoid processes and a shadow above the anterior clinoids.
4. Definite polydypsia and polyuria during the past 4 years.
5. Sudden blurring of vision in right eye, 1 year ago.

Positive findings are:

1. Acuity of vision: Left, hand movements in temporal field; right, able to read newspaper.
2. Fields: Complete left homonymous hemianopia with very little central sparing in right eye and with considerable central scotoma in left.
3. Discs: A combination of primary and post neuritic atrophy.
4. Left lower facial weakness.
5. Impairment of memory and concentration.
6. Left hemiplegia, and hemihypersthesia.  
Stereognostic sense absent in left hand and foot.

7. /

SERIAL NO. 8 (contd.)

7. X-ray appearances of supra-pituitary-cranio-pharyngeal cyst. Calcification of wall.

Operation on 11.12.31. Right transfrontal procedure. Section of right optic nerve. Complete removal supra sellar craniopharyngeal cyst. Cisternal drainage. (Part of wall, calcified, was later detected by X-ray).

Discharged 17.1.32. Followed till 15.7.39.

Histology: Fibrous wall lined by squamoid epithelium. No adamantinomatous tissue. Keratinisation. Foreign body giant cells. No calcification in section. No cholestrol.

Wall oedematous and infiltrated by dense aggregations of lymphocytes and plasma cells.

SERIAL NO. 9.  
HOSP. NO. 538. (Mr Dott).  
R.C.P. NO. 6538/22 - 6539/22.

E.B.

Male, aet 34 years, labourer.

Had appendicitis and peritonitis at age of 18 years.

Examined on 26.7.32 for:

1. Loss of libido for 3 years.
2. Progressive bilateral failure of vision.

Positive findings are:

1. Marked hypo-pituitary appearance with pale velvety skin and fine scanty hair.
2. Bilateral primary optic atrophy, more marked on the left.
3. Bitemporal hemianopia with bilateral central scotoma.
4. X-ray shows marked enlargement of sella turcica.

Diagnosis: Chromophobe adenoma of the pituitary.

Operation: Radical excision of large cystic craniopharyngioma on 29.7.32.

Post operative fatality from hyperthermia.

Histology: Epidermoid. Keratinised inspissated contents. Cholestrol. Foreign body giant cells.

Hyalinised fibrous matrix.

Pituitary remnants in the wall.

Giant cells. Foreign body giant cells. Foamy granular cells. None.



SERIAL NO. 10.  
HOSP. NO. 593. (Mr Dott).  
R.C.P. NO. 7317/32.

M.C. J.B.P.

Female, 10 years of age.

Past history - none to note.

Admitted on 20.12.32 C/O:

1. No increase in height for 1 year.
2. Somnolence for 2 months.
3. Attacks of headache for 1 month.
4. Listless and easily fatigued for some time.

Examination revealed:

1. Hypopituitarism (stature).
2. Acuity of vision: Left eye, completely blind; right eye, 2/60.
3. Bitemporal hemianopia.
4. Well marked primary optic atrophy.
5. X-ray shows definite evidence of increased intra-cranial tension with some separation of sutures. Sella turcica is definitely enlarged but not ballooned.

Diagnosis: Supra sellar craniopharyngioma.

Operation on 21.12.32. Radical extirpation of cystic craniopharyngioma. (Portion was intra sellar).

Discharged on 20.2.33.

Followed up till 1939.

Histology: Squamous epithelium. Cholestrol.

Giant cells. Stroma with old haemorrhages. Some foamy granular cells. Bone formation.



SERIAL NO. 11.  
HOSP. NO. 746. (Mr Dott).  
R.C.P. NO. 1297/34 - 9690/36 - 9941/36.

J.B.P. (South Africa).

Male, aet 24 years.

Nothing important to note in family or past history.

Examined on 14.2.34 for:

1. Suboccipital pain and attacks of headaches for 2 years.
2. Diplopia experienced 3 months ago.
3. Definite diminution of sexual activity 3-4 months.

Positive signs are:

1. Choked discs on both sides.
2. X-ray appearances do not suggest anything more than the effects of generalised increased intra-cranial pressure.  
No calcification.

Diagnosis: Chronic cisternal leptomeningitis with fluid blockage or a slowly growing type of midline cerebellar tumour.

Exploration and decompression on 18.2.34.

Ventriculogram on 6.3.34. Filling defect outlining the dome of a tumour situated pretty symmetrically in the neighbourhood of the third ventricle.

Operation /

SERIAL NO. 11 (contd.)

Operation on 14.3.34. Identification and partial removal of pituitary epidermoid tumour by transventricular route.

Discharged on 8.34.

Recurrence in 1936. X-ray showed well marked calcification.

Radical extirpation of pituitary epidermoid tumour by a right transfrontal approach.

Discharged on 17.9.36.

Histology: Major part adamantinomatous with plication and anastomosing cords. "Spangiosis". Pearls. Calcification in both pieces. Cholestrol. Myxamatus stroma. Haemorrhages fresh and old.

Invasion to brain with glial reaction around it (Mallery's phosphotungstic stain).

SERIAL NO. 12.  
HCSP. NO. 790. (Mr Dott).  
R.C.P. NO. 2044/34 - 2098/34.

E.H.

Female, 16 years old. Periods began at the age of 14 years and have been regular.

Nothing to note in family history or in past illnesses.

Admitted on 27.5.34 C/O:

1. Attacks of headaches for 6 years.
2. Nausea and vomiting for 2 months.
3. Recent vertigo.

Positive findings are:

1. Hypopituitarism (stature - absent pubic hair).
2. Very early papilloedema.
3. Depressed left corneal reflex.
4. Fine nystagmus of mild degree.
5. X-ray appearances are those of epidermoid pituitary tumour. Evidence of calcification.

Diagnosis: Supra sellar tumour. Epidermoid.

Operation on 1.6.34. Right transfrontal procedure. Removal of large calcified body and superimposed epidermoid cyst.

Died.

Histology: Adamantinomatous - squamoid.  
Keratinisation. No cholestrol. Calcification.  
Giant cells. Intense plasma cell infiltration.

Adherent /

SERIAL NO. 12 (contd.)

HOSP. NO. 538

P.C.P. NO. 2863/54 - 2867/54

Adherent to brain with surrounding glial fibrils.

One area in the brain shows complete calcification of the degenerated cells and glial reaction around it.

1. Spinal cord specimen with thickness of 10 mm.

2. Dissection of spinal cord specimen.

3. Pathology report on spinal cord.

4. Report of spinal cord specimen.

Pathology report on spinal cord.

1. Spinal cord specimen with thickness of 10 mm.

2. Dissection of spinal cord specimen.

3. Pathology report on spinal cord.

4. Report of spinal cord specimen.

Patient's name: [faded]

3 months ago.

Diagnosis: [faded]

Operational report: [faded]

Cystic degeneration of [faded]

Diagnosis: [faded]

Followed by [faded]

Histology: [faded]

SERIAL NO. 13.  
HOSP. NO. 846.  
R.C.P. NO. 2963/34 - 3007/34.

A.E.F.

Male, aet 14 years.

Examined on 20.9.34 for:

1. Squint and headache with vomiting 15 months ago.
2. Deterioration of vision 10 months ago.
3. Polyuria, polydipsia 15 months ago.
4. Weakness of left side of face for 9 months.

Positive findings are:

1. Degree of infantilism dating back to about 4-5 years.
2. Total blindness. No light reaction in pupils.
3. Complete primary optic atrophy in each eye.
4. Mild degree of hydrocephalus. Slight expansion of sella turcica and erosion of posterior clinoids. No marked depression of floor. Fluffy calcification.

Patient has been operated upon for decompression 9 months ago.

Diagnosis: Craniopharyngioma.

Operation: Radical extirpation of supra sellar cystic craniopharyngioma on 25.9.34.

Discharged on 17.11.34.

Followed up with improvement till 1945.

Histology: /

SERIAL NO. 13 (contd.)

Histology: Adamantinomatous. Whorls.

Epidermoid. Keratinisation. Foreign body giant cells. Vacuolated degenerated epithelial cells. Calcification. Imperfect bone formation.

Examination on 13.12.54 revealed:

Subjective:

1. Onset of growth for 5 years.
2. Alteration of general appearance from plump, stout to thin and emaciated-looking for 5 years.
3. Recurrent "illness attacks" during the past 5 years.
4. Attacks of unconsciousness 6 months ago.
5. Right sided hemiparesis.
6. Retrogression and dullness 4 weeks ago with partial improvement.

Objective:

1. Hydrocephalic distension of head.
2. X-ray appearances characteristic of a dermoid epidermoid cyst. Unilateral.
3. Depressed left visual acuity.
4. Clear cut bitemporal hemianopia.
5. Moderate degree of primary optic atrophy on each side.

Diagnosis: Epidermoid tumor.

Operated 7



SERIAL NO. 14.  
HOSP. NO. 892. (Mr Dott.)  
R.C.P. NO. 4232/35.

D.S.

Male, aet  $7\frac{5}{2}$  years.

Nothing important to note in past history.

Examination on 13.12.34 revealed:

Subjective:

1. Cessation of growth for 3 years.
2. Alteration of general appearance from plump, stout to thin and fragile-looking for 2 years.
3. Recurrent "bilious attacks" during the past 2 years.
4. Attacks of unconsciousness 6 months ago.
5. Right sided hemiparesis.
6. Retrogression and dullness 4 weeks ago with partial improvement.

Objective:

1. Hydrocephalic distension of head.
2. X-ray appearances characteristic of a pituitary epidermoid cyst. Calcification.
3. Depressed left visual acuity.
4. Clear cut bitemporal hemianopia.
5. Moderate degree of primary optic atrophy on each side.

Diagnosis: Pituitary epidermoid tumour.

Operation /

SERIAL NO. 14 (contd.)

Operation on 13.1.35. Left frontal procedure.  
Enormous epidermoid cyst tapped.

On 30.1.35, total removal of enormous pituitary epidermoid cystic tumour from left frontal lobe, interpeduncular space and sella turcica.

Died in coma on 31.1.35 with rapid respiration and failling circulation.

Histology: Cyst lined by squamoid epithelium. Keratinisation. Cholestrol. Foreign body giant cells. Wall eodematous with cellular infiltrations of lymphocytes and plasma cells. Calcification. Old and fresh haemorrhage.

SERIAL NO. 15.  
HOSP. NO. 896. (Mr Dott).  
R.C.P. NO. 4130/35.  
N.P. NO. 178.

J.F.

Male, 37 years of age.

Examined on 19.1.35 for:

1. Parasthesias in left thigh 1 year ago.
2. Sudden onset of frontal headaches 6 months ago.
3. Vomiting in the last 3 months.
4. Occasional incontinence of urine.
5. Loss of libido for 2 years.

Positive findings are:

1. Slight mental deterioration.
2. Bilateral papilloedema with fresh haemorrhages.
3. Slight but definite and constant depression of 2 point discrimination in left arm.
4. Dysmetria and hypertonia in left arm.

No pathological findings in C.S.F.

X-ray shows no pathological findings apart from slight thinning of the dorsum sellae.

Diagnosis: Supra tentorial lesion.

Operation: 23.1.35. Right lateral osteoplastic exploration. Hydrocephalus identified. Ventriculo-gram suggests tumour of V3. Radical extirpation done on 24.1.35.

Died /

SERIAL NO. 15 (contd.)

R.O.F. NO. 6902/35.

Died on 27.1.35.

Histology: Adamantinomatous - squamoid.

Cholestrol. Keratin. Foreign body giant cells.

Haemorrhages, old and fresh. Prussian blue stain positive. Oedematous fibrous cyst wall. Wall shows lymphocytic and plasma cell infiltration.

N.B. Subclinical foetal - transitional adenoma seen in pituitary.

- 1. Stopped growing 3 years ago.
- 2. Recurrent salivary gland tumours at 1 year, 2 years, 3 years.
- 3. Variation in weight, 100 lbs, 120 lbs, 140 lbs, 160 lbs, 180 lbs, 200 lbs, 220 lbs, 240 lbs, 260 lbs, 280 lbs, 300 lbs, 320 lbs, 340 lbs, 360 lbs, 380 lbs, 400 lbs, 420 lbs, 440 lbs, 460 lbs, 480 lbs, 500 lbs, 520 lbs, 540 lbs, 560 lbs, 580 lbs, 600 lbs, 620 lbs, 640 lbs, 660 lbs, 680 lbs, 700 lbs, 720 lbs, 740 lbs, 760 lbs, 780 lbs, 800 lbs, 820 lbs, 840 lbs, 860 lbs, 880 lbs, 900 lbs, 920 lbs, 940 lbs, 960 lbs, 980 lbs, 1000 lbs.
- 4. History of polydipsia, 1000-1500 cc per day.

Positive findings are:

- 1. Hypopituitarism.
- 2. Diminished visual acuity.
- 3. Right homonymous hemianopia, left homonymous hemianopia, central scotomata of right eye.
- 4. Proliferation of left testis, enlargement of right testis, definite atrophy.
- 5. X-ray shows definite enlargement of sella turcica. Enlargement of sella turcica.

Diagnosis: Endocrine adenoma, pituitary.

seller.

Operation

SERIAL NO. 16.  
HOSP. NO. 994.  
R.C.P. NO. 5992/35.

A.P.

Male, aet 17 years. Birth was difficult.

Left congenital club foot.

History of rheumatism.

Examined on 16.7.36 for:

1. Attacks of headache and vomiting since the age of 3 or 4 years.
2. "Blind" left eye discovered by medical school inspection at the age of 9 or 10 years.
3. Stopped growing 5 years ago.
4. Recurrent hallucinations of smell for 1 year.
5. Variation in weight (increase - loss) within 1 year.
6. History of polydipsia 2-3 years ago.

Positive findings are:

1. Hypopituitarism.
2. Diminished visual acuity.
3. Right homonymous hemianopia with hemianopic central scotoma on right side.
4. Pallor of left disc not amounting to definite atrophy.
5. X-ray shows definite expansion of sella turcica. No definite calcification.

Diagnosis: Epidermoid pituitary tumour. Supra sellar.

Operation /



SERIAL NO. 16 (contd.)

Operation on 7.8.35. Exposure of epidermoid  
pituitary cyst. Cyst emptied and solid tumour  
excavated. (Capsule adherent).

Discharged and followed till 22.4.37.

Histology: Plexiform formation of basal cells  
form. Occasional epidermoid. Oedematous wall.  
Myxomatous stroma. Lymphocytic aggregations in wall.  
Calcification. Few giant cells. Pituitary remnants  
in wall.

1. Blindness of right eye first noticed  
6 months ago.

2. Gradual loss of weight and wrinkling of skin.

3. Inactivity for the last 6 years.

Positive findings:

1. Hypopituitarism dating since puberty.

2. Right eye, blind movements at 1 metre.  
Disc is very pale with a shagreened  
left eye is 6/24. Almost complete  
hemianopia. Disc not so white.

3. Lens shows median glabrous layer of calcio-  
fibrils applied to the dorsal surface of  
the cells.

Diagnosis: Craniopharyngioma.

Operation: 14.8.35. Opening and evacuation of  
cyst of epidermoid pituitary tumour. Cyst-wall not  
removed.

Discharged.



SERIAL NO. 17.  
HOSP. NO. 1006. (Mr Dott).  
R.C.P. NO. 6075/35.

W.G.

Male, 47 years old. Odd jobs in Army. Married.  
Shaved at age of 19 years, never required to shave more  
than twice a week.

Mother died of cancer.

No family. No pregnancies for wife.

Admitted on 6.8.35 C/O:

1. Transient left frontal headaches since the  
gasing episode of last war.
2. Blindness of right eye first noticed  
5 months ago.
3. Gradual loss of weight and wrinkling of skin.
4. Impotence for the last 6 years.

Positive findings:

1. Dyspituitarism dating since puberty.
2. Right eye, hand movements at 1 metre.  
Disc is very pale with a sharp margin.  
Left eye is 6/24. Almost complete  
hemianopia. Disc not so white.
3. X-ray shows median globular layer of calci-  
fication applied to the dorsal surface of  
the sella.

Diagnosis: Craniopharyngioma.

Operation: 14.8.35. Opening and evacuation of  
cyst of epidermoid pituitary tumour. Cyst wall not  
removed.

Discharged /

SERIAL NO. 17 (contd.)

Discharged on 26.8.35.

Progressive notes till 18.1.36.

Histology: Squamoid. Prickles seen with oil immersion lens. Keratinisation. Calcification. Fibrous wall with old and fresh haemorrhages.

Appendectomy one year ago.

Admitted on 29.1.35 G/O:

1. Deterioration of vision for 3 months.
2. Headaches for 2 months.
3. Increase in weight for 1 year.

Examination revealed the positive findings:

1. Bilateral optic atrophy on both sides.
2. Vision of right eye practically absent; left eye, 6/6, J8.
3. Marked asymmetry of the face, but no facial weakness.
4. Temporal hemiparesis.
5. X-ray appearances of primarily intra-sellar expanding lesion. No calcification.

Diagnosis: Adenoma of pituitary epidermoid.

Operation on 6.2.35. Partial excision of pituitary epidermoid tumour containing cyst.

Discharged on 15.4.35. Improved; followed till 1945.

Histology: Adenomatous. Foci. Calcification. Cholesterol. Foreign body giant cells. Blood pigment.

SERIAL NO. 18.  
HOSP. NO. 1088.  
R.C.P. NO. 7869/36.

R.C.

Male, aet 34 years, married for 3 years.

No family. Shaved at the age of 14 years.

Father died of cancer.

Appendicectomy one year ago.

Admitted on 30.1.36 C/O:

1. Deterioration of vision for 2 months.
2. Headaches for 2 months.
3. Increase in weight for 1 year.

Examination revealed the positive findings:

1. Primary optic atrophy on both sides.
2. Vision of right eye practically absent;  
left eye, 6/8, J2.
3. Marked asymmetry of the face, but no facial  
weakness.
4. Temporal hemianopia.
5. X-ray appearances of primarily intra sellar  
expanding lesion. No calcification.

Diagnosis: Adenoma or pituitary epidermoid.

Operation on 5.2.36. Partial extirpation of  
pituitary epidermoid tumour containing cyst.

Discharged on 16.4.36, improved; followed till  
1945.

Histology: Adamantinomatous. Pearls. Calcifi-  
cation. Cholestrol. Foreign body giant cells.

Blood pigment.

SERIAL NO. 19.  
HOSP. NO. 1105. (Mr Dott).  
R.C.P. NO. 8151/36 - 8937/36.

M.L.

Female, aet 8 years.

Childhood ailments. History of a fall on forehead without after effects.

Examined on 2.3.36 for:

1. Squint about  $2\frac{1}{2}$  months ago.
2. Frontal headaches for 2 months, vomiting.
3. Diplopia and deterioration of vision for 3 weeks.

Positive findings are:

1. Vision: Left, 6/18, J.12; right, barely sees hand movements close in front of her.
2. Gross papilloedema of discs with fresh haemorrhage.
3. Probably concentric restriction of fields.
4. Squint. Pupillary reaction sluggish.
5. Affected trigeminal on left side.
6. Slight right lower facial weakness.
7. Deviation of tongue to left side.
8. X-ray appearances and calcification, suggestive of pituitary epidermoid tumour.

Operation on 6.3.36. Right transfrontal approach. Pituitary epidermoid cyst tapped transcortically. Removal of lower part of cyst after section of the right optic nerve. (Supra sellar).

Operation /

SERIAL NO. 19 (contd.)

Operation on 8.5.36. Frontal transventricular removal of pituitary epidermoid cyst of V3.

(Adherent to massa intermedia).

Discharged on 23.6.36.

Recurrence on 15.6.44. ( 8 years later ).

Died on 4.8.44. No P.M. done.

Histology: Adamantinomatous. Areas of squamoid epithelium. Keratinisation. Calcification. Imperfect bone formation. Foreign body giant cells. Dense fibrous capsule with lymphocytic aggregations and scanty plasma cells.



SERIAL NO. 20.  
HOSP. NO. 1153. (Mr Dott).  
R.C.P. NO. 9423/36.

J.G.

Male, aet 5 years.

Examined on 23.5.36 for:

1. Deterioration of vision for 5 months.
2. Attacks of headaches and vomiting.

Positive findings are:

1. Obesity marked.
2. Symmetrical primary atrophy on both sides.
3. Enormous expansion of the sella turcica.  
Flaky diffuse calcified shadow.

Diagnosis: Pituitary epidermoid (primarily intra sellar with upward expansion).

Operation on 1.7.36. Radical extirpation of pituitary epidermoid cystic tumour.

Discharged on 23.8.36.

? Recurrence after 6 years.

Histology: Adamantinomatous - squamoid.

Colliquactive degeneration of epithelium.

Anastomosing cords. Spaces of cells degenerating.

Cholesterol. Calcification. Giant cells. Chronic inflammatory cells. No bone. Areas of haemorrhage.



SERIAL NO. 21.  
HOSP. NO. 1224. (Mr Dott).  
R.C.P. NO. 98/36.

D.B. (South Africa).

Male, aet 29 years, mechanical foreman at the railway. Shaved at the age of 15 years, married, no family.

Tonsillectomy at the age of 10 years.

Appendicectomy at the age of 14 years.

Examined on 8.9.36 C/O:

1. Exhaustion and fatigue for 2 years.
2. Susceptible to feelings of alternating heat, flushing and cold, for 2 years.
3. Sexual desire lost for 2 years.
4. Headaches for 7 months.
5. Eye troubles for 6 months.
6. Parasthesias in left auricle.

Positive findings are:

1. Acuity of vision: Right: 6/8, J1;  
left: 6/60, J12.
2. Bilateral complete sharply cut temporal hemianopia.
3. Blood: Coagulation and bleeding times normal.  
Hb: 80%. Films show no abnormality.
4. Sella shows conspicuous globular expansion.

Diagnosis: Pituitary chromophobe adenoma.

Operation on 17.9.36. Partial extirpation of pituitary epidermoid cyst.

Discharged /

SERIAL NO. 21 (contd.)

Discharged on 10.10.36.

Followed up for 10 years in good condition.

Histology: Adamantinomatous - squamoid. Foam cells. Aggregations of small and large mononuclears in fibrous stroma. Blood pigment and fresh haemorrhage. Calcific deposits. Keratin. Glial tissue.

SERIAL NO. 22.  
HOSP. NO. 1337. (Mr Dott).  
R.C.P. NO. 2046/37.

E.B. (South Africa).

Female, aet  $14\frac{1}{2}$  years, twin, started periods recently (fortnight ago). History of a blow on eye 2 years ago. Past history of malaria, otherwise no change.

Examined on 15.4.37 for:

1. Deterioration of vision after the blow.
2. Increase in weight for 6 months.
3. Polydipsia last weeks.

Positive findings are:

1. Light perception in right eye. Left blind.
2. Primary optic atrophy on both sides, more marked pallor on left.
3. X-ray appearance: flat and open sella turcica.

Diagnosis: Glioma of optic chiasma or anterior end of V3 or epidermoid pituitary tumour.

Operation: 27.4.37. Radical extirpation of peculiarly thin walled supra pituitary cyst.

Discharged on 15.5.37 in good condition.

Histology: Cyst lined by epithelium varying from a columnar mucin secreting type to immature epidermoid type. Calcific deposit. Osteoid bone. Few granular histiolytes in wall.

SERIAL NO. 23.  
HOSP. NO. 1395. (Mr Dott).  
R.C.P. NO. 3185/37.

MRS. M.S.

Aet 37 years. She has 6 children (the youngest aged 4).

Examined on 14.8.37 for:

1. Amenorrhoea dating from the last confinement.
2. Frontal headaches 5-6 years ago.
3. Rapid increase in weight recently.
4. Somnolence.
5. Fainting and vomiting recently.
6. Loss of memory, periods of amnesia.

Positive findings are:

1. Obesity.
2. C.S.F.: W.R. egative. Proteins 80 mgm%.  
Cell count: 4/cmm.
3. X-ray shows characteristic pressure absorption of posterior clinoids.  
(No calcification).
4. Visual acuity: J1 and 6/8 (corrected).
5. High grade of papilloedema in fundi.
6. Concentric restriction of the visual fields with enlargement of the blind spots.

Ventriculography 18.8.37.

Operation: Transfrontal extirpation lower pole intraventricular epidermoid tumour.

Discharged on 10.11.37.

Refilling /

SERIAL NO. 23 (contd.)

Refilling of cyst with symptoms. Puncture on repeated occasions.

Followed till 5.1.46.

Histology: Squamoid epithelium. Central cells are degenerating. Myxamatus stroma. Granular foamy cells. No keratinisation. No calcification. No giant cells.

- 1. Deterioration of vision 2 years.
- 2. Attacks of loss of power in right arm and leg for 2 years.
- 3. Semiblindness for 13 months.
- 4. Increase in weight rapidly for 2 years.
- 5. Karyolipia and polyuria 2 years ago.

Negative findings are:

- 1. Feminine character of pelvic organs.
- 2. Optic blindness. No optic atrophy.
- 3. Primary bilateral optic atrophy.
- 4. Nystagmus.
- 5. X-ray shows a mass the lower part of which lies in the sella turcica with the upper part of which projects upwards into the cavity of the skull in an upward and backward direction.

Diagnosis: Supra sellar meningioma.

Operation on 20.2.46. Histology confirmed pituitary epidermoid tumour.

Good /



SERIAL NO. 24.  
HOSP. NO. 1403. (Mr Dott).  
R.C.P. NO. 3292/37.  
N.P. NO. 786.  
P.M. NO. RIE/429/37.

J.B.

Male, aet 34 years, works in a grocer's shop.

History of an accident (fell off a lorry 14 years ago).

Examined on 15.7.36 for:

1. Headaches for  $3\frac{1}{2}$  years.
2. Deterioration of vision  $3\frac{1}{2}$  years.
3. Attacks of loss of power in right arm and leg for 2 years.
4. Somnolence for 18 months.
5. Increase in weight rapidly for 1 year.
6. Polydipsia and polyuria 2 years ago.

Positive findings are:

1. Feminine character of pubic hair.
2. Total blindness. No light perception.
3. Primary bilateral optic atrophy.
4. Nystagmus.
5. X-ray shows a mass the lower part of which lies in the sella turcica and the upper part of which projects upwards into the cavity of the skull in an upward and backward direction.

Diagnosis: Supra sellar meningioma.

Operation on 25.8.37. Subtotal removal of pituitary epidermoid tumour.

Good /



SERIAL NO. 24 (contd.)

Good immediate recovery. Died later.

Histology: Adamantinomatous. Basal cell layer, irregular cells, whorls of cells in the centre. Abundant keratin with evidence of calcification. Myxamatus stroma with granular cells. Marked fresh haemorrhage.

SERIAL NO. 25.  
HOSP. NO. 1494. (Mr Dott).  
R.C.P. NO. 4802/38 - 4895/38.

R.J.H.

Male, aet 19 years, 9 months.

Nothing important to note.

Examined on 20.12.37 C/O:

1. Polydipsia over a very long time and recent polyuria.
2. Headaches for 7 years.
3. Failure of vision for 6 months.
4. Access of adiposity for 1 year.

Positive findings are:

1. Frohlich's syndrome.
2. Visual acuity: Left: 6/12, J1;  
right: 6/18, J3.
3. Pale discs.
4. X-ray suggestive of an epidermoid tumour commenced within the sella turcica.  
No calcification.

Operation on 19.1.38. Partial extirpation of pituitary epidermoid tumour (adherent).

Discharged on 13.2.38.

Followed up till 10.1.41.

Histology: Mass of keratinised material, cholesterol but no calcification. Giant cells are visible. Lymphocytic infiltrations and remnants of pituitary gland are seen in the capsule. Haemorrhage, old and fresh, detected.

SERIAL NO. 26.  
HOSP. NO. 1501. (Mr Dott).  
R.C.P. NO. 869.  
P.M. NO. RIE/25/38.

J.C.

Female, aet 18 years. Nothing important to note in the past history.

Examined on 6.1.38 for:

1. Attacks of headaches with vomiting dating back to the age of 5 or 6 years. Severe in last 3 years.
2. Sleepiness.
3. Deterioration of vision for 3 years, with diplopia. Recent rapid progress.
4. Drowsiness, with restlessness and twitchings.

Positive findings are:

1. Drowsiness.
2. Nystagmus. No light perception. Primary optic atrophy.
3. Slight deviation of the tongue to the right.
4. No planter response on the right side.
5. Considerable ataxia.
6. X-ray showed evidence of a pituitary epidermoid cyst lying upon the sella turcica and extending well back into the interpeduncular space.

Operation on 9.1.38. Transcerebral aspiration of pituitary epidermoid cyst.

Died on 13.1.38.

Histology: /

SERIAL NO. 26 (contd.)

Histology: Mainly adamantinomatous. One part squamoid. Pearls. Calcification. Cholestrol. Foreign body giant cells.

Plication and anastomosing cords. Myxomatous degeneration of the cores. Adherent to brain with glial reaction.

Naked eye: Partly solid and partly cystic.

Cause of death: Meningitis due to liberation of infection from the cyst.

Examination revealed:

1. Diplopia.
2. Loss of vision could not be corrected.
3. Blurred vision.
4. Rather pale external parts of optic chiasm.
5. Papillary reaction slight.
6. Lack of concentration.
7. X-ray appearance of a pituitary adenoma.

Calcification.

Operation on 11.6.37. Radical excision of pituitary gland with removal of surrounding context or surface of the brain.

Died on 11.6.37.

R.M. /

SERIAL NO. 27.  
HOSP. NO. 1516. (Mr Dott).  
R.C.P. NO. 5458/38.  
P.M. NO. RIE/196/38.

MRS. S.W.

Aet 54 years. Menopause at age of 50 years.

Nothing important to note in past history.

Admitted on 8.3.38 C/O:

1. Buzziness on top of head 3 years ago.
2. Failure of vision for 3 years.
3. Attack of headache fortnight ago.
4. Diplopia within last few months.

Examination revealed:

1. Drowsiness.
2. Acuity of vision could not be ascertained.
3. Bitemporal hemianopia.
4. Rather pale temporal parts of optic discs.
5. Pupillary reactions sluggish.
6. Lack of concentration.
7. X-ray appearances of a pituitary epidermoid tumour of entirely supra sellar variety.

Calcification.

Operation on 11.3.38. Radical extirpation of pituitary epidermoid cystic tumour. (Adherent to anterior surface of the stalk).

Died on 11.4.38.

P.M. /



SERIAL NO. 27 (contd.)

P.M. revealed acute cerebral softening.

Histology: Adamantinoma. Pearls with calcification. Aggregations of lipophage cells in the stroma.

Hematology 12 years ago. ? gastric ulcer.

Old attack of pleurisy.

Examined on 22.6.33 by:

1. Aching pain above and behind right eye, for months, recurring.
2. Blurring of vision 6 months ago.
3. Recurrent hemianopia. Diplopia 6 months ago.

Positive findings are:

1. Prominent bilateral hemianopia.
2. Tent shaped cells farvica with rather short but not broad looking dorsal cells and posterior clinoids.
3. Slight pallor of optic discs.
4. Visual acuity diminished (right 1/60; left 6/60).

Diagnosis: Supra-sellar tumour (? Meningioma).

Operation on 3.7.33. Left transfrontal craniotomy and exploration. Metastases of tumour ? aneurysm. Arteriogram shows no aneurysm.

Operation on 12.8.33. Radical removal of supra-sellar epidermoid tumour.

Discharged /



SERIAL NO. 28.  
HOSP. NO. 1561. (Mr Dott).  
R.C.P. NO. 7235/38 - 7453/38.

R.M.L. (South Africa).

Male, aet 38 years, clothes outfitter, married,  
got children.

Herniotomy 12 years ago. ? gastric ulcer.

Old attack of pleurisy.

Examined on 22.6.38 for:

1. Aching pain above and behind right eye,  
for months, recurring.
2. Blurring of vision 6 months ago.
3. Temporal hemianopia. Diplopia 5½ months  
ago.

Positive findings are:

1. Homonymous bilateral hemianopia.
2. Boat shaped sella turcica with rather short  
but not eroded looking dorsum sella and  
posterior clinoids.
3. Slight pallor of optic discs.
4. Visual acuity diminished (right 1/60;  
left 6/60).

Diagnosis: Supra sellar tumour (? Meningioma).

Operation on 3.7.38. Left transfrontal chiasmal  
exploration. Retrochiasmal tumour ? aneurysm.

Arteriogram shows no aneurysm.

Operation on 14.8.38. Radical removal of a  
supra sellar epidermoid tumour.

Discharged /

SERIAL NO. 28 (contd.)

Discharged on 13.9.38.

Histology: Mainly adamantinomatous. Marked plication and anastomosing bands. Few areas of surface epithelial character. Stroma myxomatous.

SERIAL NO. 29.  
HOSP. NO. 1849. (Mr Dott).  
R.C.P. NO. 2949/40.

A.K.

Male, aet 32. Rigger, married for 5 years,  
no family.

Nothing important to note in past history.

Admitted on 12.2.40 C/O:

1. Increase in weight 6-7 years ago.
2. Polyuria and polydipsia for 4 years.
3. Gradual failure of vision for 4 years.
4. Loss of libido and impotence for 4 years.
5. Loss of hair for 7-8 years (now shaves once or twice a week only).
6. Hypersomnolence for 2 years.
7. Headaches recently.

Examination revealed:

1. Hypopituitarism (skin - hair - obesity - genitalia).
2. X-ray characteristic of a supra sellar cyst. Calcification.
3. Acuity of vision (left 6/18 - J.8; right 1/60), altitudinal and bitemporal hemianopia. Pallor of both discs.
4. Sluggish right pupillary reactions.
5. Loss of memory for recent events and lack of concentration.
6. Basal metabolic rate - 26.

Diagnosis: Epidermoid cyst.

Operation /

SERIAL NO. 29 (contd.)

Operation on 18.2.40. Evacuation and partial extirpation of pituitary epidermoid. (Adherent to brain). Discharged on 13.3.40. Followed till 12.8.45.

Histology: Surface epithelium. Pearl formation. Wall densely fibrous. Some calcific deposits and lymphocytic aggregations.

3. Pals in right eye for 4 weeks, and in right upper limb for 5 weeks.

Positive findings are:

1. Asymmetric face with hypertonus and contracture on right side.
2. Ruffy eyelids - photophobia.
3. General impairment of mental faculties.
4. Cardiac hypertrophy. B.P. 210/140. Signs of atherosclerosis, varicose veins and priapisms.
5. Binocular homonymous.
6. Arteriosclerotic foci with slight temporal pallor.
7. S.E.P. Total proteins 350 mg%, albumin 170 mg%, globulin 180 mg%. Schick test negative.
8. Normal X-ray picture.

Diagnosis: Epidermoid tumour.

Operation on 12.3.40. Partial extirpation of

epidermoid tumour. (Adherent to brain and optic chiasm).

Histology:

SERIAL NO. 30.  
HOSP. NO. 1862. (Mr Dott).  
R.C.P. NO. 3232/40.

MISS G.H.

Aet 52 years.

Nothing important to note in past history.

Examined on 9.5.39 C/O:

1. Subject to attacks of headache for 10 years.
2. Deterioration of vision for 9 months.
3. Pain in right eye for 4 weeks, and in right upper limb for 5 weeks.

Positive findings are:

1. Asymmetric face with hypertonus and contracture on right side.
2. Puffy eyelids - photophobia.
3. General impairment of mental faculties.
4. Cardiac hypertrophy. B.P. 216/140.  
Oedema of ankles, varicose veins and phleboliths.
5. Bitemporal hemianopia.
6. Arteriosclerotic fundus with slight temporal pallor.
7. C.S.F.: Total proteins 100 mgm%, cells 1/cmm.  
Colloid gold negative.
8. Normal X-ray picture.

Diagnosis: Epidermoid tumour.

Operation on 13.3.40. Partial extirpation sub-chiasmal tumour. (Supra sellar cyst. Adherent to the tuber cinereum).

Histology: /



SERIAL NO. 30 (contd.)

Histology: Adamantinomatous. Anastomosing cords.  
Highly plexiform. Early central vacuolation of  
epithelial cells. Calcification. Keratin pearls.  
No giant cells.



SERIAL NO. 31.  
HOSP. NO. C388. (Mr Dott).  
R.C.P. NO. 8057/41.

J.B.

Male, 46 years of age, married for three years.  
No family. Clerk.

History of trauma (fell on the ice) 3 years ago.

Admitted on 18.6.41 C/O:

1. Attacks of headaches for  $2\frac{1}{2}$  years.
2. Deterioration of vision for 6 months.
3. Fatigue, lassitude and hypersomnolence for 5 months.

Never exhibited any desire for sexual intercourse.

Never had any intercourse.

Examination revealed:

1. Hypopituitarism (stature - hair - skin).
2. Visual acuity: Right, J1; left, J16.
3. Right temporal hemianopia.
4. Primary optic atrophy, well advanced on the left side.
5. Sluggish tendon reflexes (symmetrical).
6. C.S.F. normal pressure, protein content, and cell count.
7. Blood count: R.B.C's: 4900000. Hb. 100%.  
W.B.C's: 5000.
8. Negative X-ray appearance as to deformation of the sella and abnormal calcification.

Diagnosis: Supra sellar epidermoid tumour.

Operation: /

SERIAL NO. 31 (contd.)

Operation: 25.6.41. Total extirpation of cystic epidermoid tumour.

Discharged home on 16.8.41.

Histology: Epidermoid. Keratinisation.

Calcification. Cholestrol. Foreign body giant cells.

Part showing adamantinomatous texture.

SERIAL NO. 32.  
HOSP. NO. C543. (Mr Dott).  
R.C.P. NO. 7092/41.

J.S.

Male, aet 26 years.

History of rheumatic fever and "St. Vitus Dance".

Examined on 26.3.41 C/O:

1. At about 12 years old he first complained of frontal headache.
2. Troubles with his eyes 4 months later.
3. Nocturnal aneurisis from the age of 10 years together with polydipsia.
4. Feels cold.
5. Fits started 8 years ago.

Positive findings are:

1. Hypopituitarism (stature, genitalia, hair).
2. Visual acuity: Left, 6/12, J1 (corrected); right, blind.
3. Temporal hemianopia in the remaining left eye.
4. Right eye complete primary optic atrophy, left shows more early atrophy.
5. X-ray showed expanded sella turcica. Calcification.

Diagnosis: Pituitary epidermoid tumour.

Operation: Emptying and partial removal of a large pituitary epidermoid cyst (adherent to brain).

Discharged home on 5.5.41.

Followed till 3.1.42.

Histology: /

SERIAL NO. 32 (contd.)

Histology: Mainly squamoid epithelial lining.

Wall is dense and fibrous. Cellular reactions of lymphocytes and plasma cells. Areas of haemorrhage.

No pituitary remnants. No keratinisation.

No calcification in section.

SERIAL NO. 33.  
HOSP. NO. C769. (Mr Dott).  
R.C.P. NO. 9256/41.

W.M.

Male, aet 25 years, miner, married for 9 months.

No family.

Nothing important to note in past history.

Examined on 30.8.41 for:

1. Attacks of headache for 6 months.
2. Deterioration of vision 6 weeks ago.

Positive findings are;

1. Visual acuity: Left: 6/60, J19;  
right; 6/18, J6.
2. Scotomatous type of bitemporal hemianopia.  
Characteristic features of a lesion in the  
pituitary region pressing on the chiasm.
3. X-ray shows expanding lesion of the pituitary  
neighbourhood. (No calcification).

Diagnosis: Supra sellar pituitary tumour.

Operation on 19.9.41. Total extirpation of  
solid supra sellar pituitary epidermoid.

Discharged on 6.11.41. Followed for 4 years  
later.

Histology: Uniform squamoid cells. Anastomosing  
bands of tumour cells. Myxomatous stroma.

N.B. Oedema and polymorphonuclear infiltration  
of the epithelium is visible.



SERIAL NO. 34.  
HOSP. NO. C992. (Mr Dott).  
R.C.P. NO. 1446/42.  
N.P. NO. 1924.  
P.M. NO. EM/190/A.

MRS. M.A.

Aet 52 years. Amenorrhoea at the age of 38 years. Blind left eye since the age of 7 years after trauma.

Father died of cancer of mandible.

Admitted on 6.3.42 C/O:

1. Headaches for 18 months with delirium.
2. Disturbances of vision.
3. Polyuria, polydipsia, 4 months ago.

Examination revealed:

1. Hypopituitarism.
2. Anosmia of right side.
3. Acuity of vision: Right: 6/7.5, J8;  
left: finger movements at 1 metre distance.
4. Right temporal hemianopia.
5. Left chorioretinitic changes of severe degree.
6. Affection of trigeminal and of sensations on right side of the body.
7. Right corneal reflex depressed. Right knee jerk slightly depressed. Abdominals absent. Planter responses brisk.
8. Abnormally large deep and rounded sellar cavity. No calcification.

Diagnosis: /



SERIAL NO. 34 (contd.)

Diagnosis: Intra sellar tumour.

Operation: 17.3.42. Right transfrontal procedure. Evacuation of ? epidermoid cyst.

Died on 7.4.42 due to chronic renal and liver failure secondary to arteriosclerosis. Rheumatic mitral valve.

Histology: Cyst wall lined by epidermoid epithelium. Wall shows strands of pituitary cells, plasma cells and lymphocytes. Cholestrol. Granular cells. "Rathke's Cyst".

SERIAL NO. 35.  
HOSP. NO. C1905. (Mr Dott).  
R.C.P. NO. 9056/43.

R.U.

Male, aged 21 years and 8 months.

One sister is left-handed. Family history is otherwise entirely negative.

Head injury at the age of 12 years.

Examined on 25.6.43 for:

1. Headache 4 years ago.
2. Physically easily fatigued.

Positive findings are:

1. Pituitary dwarfism - poorly developed secondary sex organs.
2. Visual acuity: Left eye, J1; right eye, J8. Scotomatosusly. Definite bitemporal hemianopia. Temporal pallor of both discs. Fine lateral nystagmus.
3. Definite right lower facial weakness.
4. X-ray appearances are very typical of primarily intra sellar pituitary epidermoid.

Diagnosis: Pituitary epidermoid tumour.

Operation on 21.7.43. Subtotal extirpation of pituitary epidermoid cystic tumour. (Adherent to the stalk).

Discharged on 3.9.43. Followed till 13.2.47.

Histology: /

SERIAL NO. 35 (contd.)

Histology: Squamoid epithelium lining.

Cholestrol with giant cells. Haemorrhage (old-organising and fresh). Remnants of pituitary in the wall and lymphocytic aggregations.

Nothing to note in previous illnesses.

Examined on 7.10.43 for:

Attacks of headache for 2 years; vomiting.

Positive findings are:

1. Orientation to time is vague.
2. Acuity of vision (right, only light perception).
3. Binasal temporal hemianopia with central scotomata.
4. Primary optic atrophy right eye. Pale left eye with definite superimposed papilloedema.
5. X-ray appearances are those of an intra-sellar neoplasm. There is no abnormal calcification in the supra-sellar area.

Diagnosis: Pituitary epidermoid cyst.

Tapping of cyst on 10.10.43.

Operation on 12.10.43. Ventriculography and subsequent excision of pituitary epidermoid tumour. (Address to tubercle region).

Ends

SERIAL NO. 36.  
HOSP. NO. C2041. (Mr Dott).  
R.C.P. NO. 284/43.  
N.P. NO. 2349/B.

A.P.

Male, aet 12, school boy, not fond of physical exercises.

Nothing to note in previous illnesses.

Examined on 7.10.43 for:

Attacks of headaches for 2 years; vomiting.

Positive findings are:

1. Orientation to time is vague.
2. Acuity of vision (right, only light perception).
3. Pronounced temporal hemianopia with central sparing.
4. Primary optic atrophy right disc. Pale left side with definite superimposed papilloedema.
5. X-ray appearances are those of an intrasellar neoplasm. There is no abnormal calcification in the supra sellar area.

Diagnosis: Pituitary epidermoid cyst.

Tapping of cyst on 10.10.43.

Operation on 15.10.43. Ventriculography and subsequent extirpation of pituitary epidermoid tumour. (Adhesive to tuberal region).

Sudden /

SERIAL NO. 36 (contd.)

Sudden collapse. Death with increasing signs of disturbed function of the hypothalamus and upper brain stem (acute circulatory).

Histology: Epidermoid and adamantinomatous.

Plication. Whorls. Early pearl formation.

Keratinisation, and early calcification. Myxamatus degeneration of stroma. Granular foamy cells inside the epithelial masses.

A. Polyuria and polydipsia 6 weeks.

Examination revealed:

1. Hypopituitarism.

2. Hydrocephalic head.

3a. Inosmia - right nostril.

4. Papilloedema, bilateral temporal hemianopia.  
Visual acuity: 6/18, 30, both eyes.

5. Lower facial weakness.

6. Hypotonus - exaggerated reflexes.  
Hyperreflexia to touch.

7. Flaccid gait. Calcification above the sella and to the right of midline.

Diagnosis: Supra sellar epidermoid (presence of

hydrocephalus suggested a cystic portion extending to

75).

Operations /



SERIAL NO. 37.  
HOSP. NO. C2196. (Mr Dott).  
R.C.P. NO. 1233/43 - 9174/43.  
N.P. NO. 2404.

J.A.

Male, 14 years of age.

History of tuberculosis in family.

Admitted on 12.7.43 C/O:

1. Severe headaches and giddiness for 4-5 years with recent accompaniment of vomiting.
2. Deterioration of vision for 8 weeks and diplopia for 6 weeks.
3. Polyuria and polydipsia 6 weeks.

Examination revealed:

1. Hypopituitarism.
2. Hydrocephalic head.
3. Anosmia - right nostril.
4. Papilloedema, bilateral temporal hemianopia, visual acuity: 6/18, J2, both eyes.
5. Lower facial weakness.
6. Hypotonus - exaggerated reflexes.  
Hypersensitiveness to touch.
7. Flattened sella. Calcification above the sella and to the right of midline.

Diagnosis: Supra sellar epidermoid (presence of hydrocephalus suggested a cystic portion extending to V3).

Operations /



SERIAL NO. 37 (contd.)

Operations on: 15.7.43. Tapping of cyst  
(multi-locular).  
30.7.43. Extirpation of tumour.  
1.12.43. Transventricular  
extirpation from V3.

Died on 4.12.43.

Histology: Epidermoid. Keratin. Cholestrol  
giant cells. Calcification. Granular cells.  
Parts are adamantinomatous. Stroma haemorrhagic.  
Cellular infiltration of lymphocytes. Adherent to  
brain.

SERIAL NO. 38.  
HOSP. NO. C2244.  
R.C.P. NO. 1388/43.

N.K.

Female, aet 7 years.

Ordinary childhood ailments without complications.

Admitted on 27.11.43 C/O:

1. Retarded physical growth since the age of 3 months.
2. Headaches and vomiting for 2 years.
3. Shaky hands for few months.
4. Attack of tonic convulsions recently.

Examination revealed:

1. Head very slightly hydrocephalic.
2. Diminished visual acuity.
3. Pale discs with papilloedema.
4. X-ray shows very clearly the outline of the cyst in the third ventricle.

Diagnosis: Supra sellar epidermoid tumour.

Operation: Tapping of cyst on 4.12.43.

Radical extirpation supra sellar pituitary epidermoid tumour on 7.12.43.

Died in deep coma on 22.12.43.

Histology: Squamoid and adamantinomatous.

Pearls with giant cells.

Calcification. Hyaline connective tissue.

SERIAL NO. 39.  
HOSP. NO. C2745. (Mr Dott).  
R.C.P. NO. 4745/44.

E.T.

Female, aet 10 years, left-handed.

Nothing important to note in family and past history.

Examination on 13.6.44 revealed the following positive findings:

Subjective:

1. Headaches 10 months ago, with vomiting.

Objective:

1. Visual acuity: 6/6 and J1, each eye.
2. Bilateral early papilloedema.
3. Bilateral intention tremor, very slight.
4. Very slight ataxia in the knee - heel test and a tendency to fall backwards in Romberg's test.
5. X-ray shows slight spreading of sutures. Normal sellar cavity with slight erosion of dorsum and heavy calcification inside and above.

Diagnosis: Supra sellar pituitary epidermoid.

Operation on 20.6.44. Radical extirpation of pituitary supra sellar epidermoid cyst. (Optic division).

Discharged. Followed till 30.6.46.

Histology: /

SERIAL NO. 39 (contd.)

Histology: Squamoid and adamantinomatous.

Cholesterol with giant cells. Keratinisation with  
giant cells. Calcification. Lymphocytic and plasma  
cell infiltration in the wall. Brain tissue adherent  
to wall.

SERIAL NO. 40.  
HOSP. NO. C2966. (Mr Dott).  
R.C.P. NO. 6457/44.

E.V.

Male, aet 7 years.

Nothing important to note in past illnesses.

Examined on 26.9.44 for:

1. Pain above left eye for 5 months, vomiting.
2. Diplopia 3 months ago.
3. Deterioration of vision since then.

Positive findings are:

1. Undue stoutness.
2. Visual acuity: Light perception.  
Fundi show still active papilloedema overlying a secondary optic atrophy.
3. Left incomplete 6th nerve paresis and nystagmus.
4. X-ray shows widened sutures, deepened pituitary fossa with some erosion of the dorsum sellae. A calcification in the third ventricle.

Diagnosis: Pituitary epidermoid tumour.

Operation on 6.10.44. (Tumour seen to protrude upwards from the sella).

Died of accidental haemorrhage.

Histology: Epidermoid. Adamantinomatous.

Pearls with ghosts of degenerating epithelial cells.

Fresh haemorrhage. Fibrovascular supporting tissue.



SERIAL NO. 41.  
HOSP. NO. C3329. (Mr Dott).  
R.C.P. NO. 6104/44.  
N.P. NO. 2635.

MRS. M.L.

Aet 34 years, married 10 years ago, has two children. Menestruation began at the age of 18 years, regular.

Admitted on 29.8.44 for:

1. Amenorrhoea since the second birth (child is  $2\frac{3}{4}$  years old).
2. Undue persistence of lactaction after weaning the child.
3. Attacks of headaches for 2 years, associated with vomiting recently.
4. History of deterioration of vision 8 years ago, aggravated recently.

Examination presents the following positive findings:

1. Defective vision.
2. Clear cut hemianopia in both eyes.
3. Both discs are well defined. Temporal half of right disc is on the pale side.
4. Asymmetrical face.

Diagnosis: Supra sellar adenoma.

Operation on 6.9.44. Radical extirpation of supra sellar pituitary epidermoid cyst (left trans-frontal).

Died of cerebral oedema.

Histology: /



SERIAL NO. 41 (contd.)

Histology: Epidermoid. Wall fibrosed with adhesions to brain. Calcification of pearls. Cholestrol with giant cells. Old haemorrhage (haemosiderin - histiocytes). In one area the lining is abraded and foam cells, making their way into the lumen, are seen.

- 1. Deterioration of vision for 1 year.
- 2. Headache with vomiting.
- 3. Getting better in 1st 2nd year.

Positive findings were:

- 1. Gross bilateral optic atrophy.
- 2. Left eye double fingers of 5 vision. Right eye finger narrow's only.
- 3. The lower right temporal and lower left nasal fields remain to normal vision.
- 4. No papillary reaction.
- 5. Enlargement of the pituitary fossa with destruction of the anterior clinoid process, thinning of the sphenoid wing. Calcification plates.
- 6. C.S.F. normal.

Diagnosis: Pituitary epidermoid cyst.

Operation on 19.3.45. Subtotal excision of pituitary epidermoid cyst.

Died on 20.5.45.

Histology: /

SERIAL NO. 42.  
HOSP. NO. C3710. (Mr Dett).  
R.C.P. NO. 400/45.

A. Mc. D.

Aet 11 years, female.

Nothing important to note in past history.

Examined on 28.4.45 for:

1. Attacks of somnolence and a tendency to hypersomnia since the age of 4 years.
2. Deterioration of vision for 1 year.
3. Headaches with vomiting.
4. Getting fatter in the last year.

Positive findings are:

1. Gross bilateral optic atrophy.
2. Left eye counts fingers at 2 metres.  
Right eye: finger movements only.
3. The lower right temporal and lower left nasal fields remain to confrontation.
4. No pupillary reaction.
5. Enlargement of the pituitary fossa with some destruction of the anterior clinoid and thinning of the dorsum sellae.  
Calcification flake.
6. C.S.F. normal.

Diagnosis: Pituitary epidermoid cyst.

Operation on 16.5.45. Subtotal extirpation of pituitary epidermoid cyst.

Died on 20.5.45.

Histology: /

SERIAL NO. 42 (contd.)

Histology: Epidermoid. One part adamantinomatous.

Pearls. Calcification. Imperfect bone formation.

Giant cells around keratinising areas and cholestrol.

Wall densely fibrous. Haemorrhage into wall.

Admitted on 10.2.25

1. Diminished visual acuity on the left side, relieved by medical treatment in 1924.

2. Attacks of headaches for 1 year.

Examination revealed:

1. Visual acuity: Right: 6/12, 30; Left: 6/18, 30.

Fields: Right: restriction to right and red in superior and temporal half of field. Blind spot enlarged and crowding the midline in lower part. Left: complete temporal hemianopia without superior extension.

Fundi: Right: normal; left: optic atrophy.

2. Slight left lower facial weakness.

3. Calcified nodule in midline about 1 cm. above posterior clinoid. Sella normal. No abnormal shape and size.

Diagnosis: Craniopharyngioma.

Operation: Total extirpation pituitary gland and supra-sellar (solid) on 10.2.25.

Discharged on 10.4.25. Followed by visual improvement.

Discharged on 10.4.25.

Followed till 10.12.25.

Histology: /

SERIAL NO. 43.  
HOSP. NO. M523. (Mr Dott).  
R.C.P. NO. 1293/42.

A.B.T. McC.

Male, aet 20 years.

Nothing of importance to note in past history.

Admitted on 19.2.42 for:

1. Diminished visual acuity on the left side, detected by medical examination in 1941.
2. Attacks of headaches for 1 year.

Examination revealed:

1. Visual acuity: Right: 6/12, J1;  
left: 6/12, J4.  
Fields: Right: restriction to white and red in screen on temporal half of field. Blind spot enlarged and crossing the midline in lower part. Left: complete temporal hemianopia without macular sparing.  
Fundi: Slight macular choroiditis more on left eye.
2. Slight left lower facial weakness.
3. Calcified nodule in midline about  $\frac{1}{2}$  cm. above posterior clinoids. Sella turcica of normal shape and size.

Diagnosis: Craniopharyngioma.

Operation: Total extirpation pituitary epidermoid supra sellar (solid) on 3.3.42. (Adherent to tuber cinereum).

Discharged on 5.4.42.

Followed till 24.11.45.

Histology: /

SERIAL NO. 43. (contd.)

Histology: Adamantinomatous. Anastomosing strands enclosing myxomatous tissue. Foamy granular cells. Little keratinisation. One part differentiated to squamous epithelial cells undergoing degenerative changes.

4. Increasing weight.

5. Hyperostosis.

Examination revealed bilateral hemianopia with optic atrophy.

X-ray appearances of supra sellar calcification.

Diagnosis: Craniopharyngioma.

Histology: Adamantinomatous. Pearls. Early calcification. No cholesterol. No giant cells. Occasional stream. Cellular reaction in surrounding brain tissue.



SERIAL NO. 44.  
HOSPL. NO. Mr. Pattison.  
R.C.P. NO.6721/35.

C.S.

Male, aet 37 years, married.

C/O:

1. Visual deterioration for 3 years.
2. Increasing weight.
3. Hypersomnolence.

Examination revealed bitemporal hemianopia with optic atrophy.

X-ray appearances of supra sellar calcification.

Diagnosis: Craniopharyngioma.

Histology: Adamantinomatous. Pearls. Early calcification. No cholestrol. No giant cells. Oedematous stroma. Glial reaction in surrounding brain tissue.



SERIAL NO. 45.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 9484/36.

J.R.

Male, aet 15 years, single.

C/O:

1. Retardation of growth since the age of 9 years.
2. Headaches, vomiting.
3. Polydipsia.
4. Failure of eyesight 14 months.
5. Recent hypersomnolence.

Examination revealed:

1. Physical development of boy of 9.
2. Obesity.
3. Rudimentary genital development.
4. Bilateral primary optic atrophy with bitemporal hemianopia.

Operation.

Died from hyperthermia following evacuation of cyst above optic chiasma.

Histology: Adamantinomatous. Pearls. Calcification. Myxomatous stroma. Foamy granular cells. Imperfect bone formation. Glial reaction around pieces of tumour in brain.

SERIAL NO. 46.  
HOSP. NO. (Mr Pattison).  
R.C.P. NO. 6490/35, 8105/35.

J.W.

Female.

History not available.

Histology: Epidermoid (squamous acanthotic character). Few areas of adamantinomatous structure. Degeneration of epithelium. Myxamatous supporting tissue. No calcification.

SERIAL NO. 47.  
HOSP. NO. (Mr Craig).  
R.C.P. NO. 6056/41.

MRS. G.

Examined for progressive failure of vision for 11 months. Reduction in size of visual fields was found.

X-ray shows enlarged sella turcica with a ? cyst wall visible above it.

Histology: Cyst wall lined with epidermoid tissue. Pearls. No calcification.