

Jacobi

DERMOID CYST

OVER THE CENTRE OF

THE LARGE FONTANELLE.

BY

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DERMOID CYST OVER THE CENTRE OF THE LARGE
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BY A. JACOBI, M.D., LL.D.,
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Av., a Cuban boy, was presented when he was eight months old, with a tumor of the size of a coffee bean over the centre of his large fontanelle. It was first noticed when the child was a few months old; at that time it had the size of a pea. The fontanelle was open and of the size it usually has at the age of eight months; pulsation could be felt through it, and crying raised it. The tumor was of the color of the scalp, not vascular, not congested, not sensitive, and covered with hair. It was not changed in size or shape by compression, but could be depressed (the fontanelle being still fibrous). Some pulsation could be felt through the tumor, and the latter would rise with forced expiration (crying). These symptoms were attributed to the condition of the fontanelle on which the tumor was situated, but the operation was postponed on account first of the possibility of a mistake, and of the increased safety of a surgical procedure in later years when ossification would have been completed.

The child was again presented in May, 1898, when he was four years and nine months old. The tumor had the size of a hazelnut, was covered with hair, not discolored, not vascular, not markedly depressible, but elastic and semi-fluctuating, and slightly compressible under bilateral pressure. It was not transparent. Its shape was spherical; it had no pedicle, but its base appeared narrower than the rest of the tumor. It was not removable from its point of attachment, which was quite firm. The skin on top, at the greatest distance from the skull, appeared rather thin. There was no pulsation in or through the tumor, and no change with exertion or with crying.

DIAGNOSIS.—Congenital dermoid cyst. No possible mistake for meningocele.

A longitudinal incision through the covering scalp proved the skin of normal thickness. The capsule was easily found

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and readily separated from the surrounding tissue until the periosteum was reached. There it and the capsule were firmly adhering. In the attempt at separating them a small opening was accidentally made into the tumor, and some little of the contents was lost. The opening was kept closed with pincers. The periosteum was torn off the bone to the extent of a square cubic centimetre. This part of the periosteum which remained attached to the tumor was rather thin. During the latter part of the operation the cause of the difficulty in finishing it quickly was found in the fact that there was a depression of the bone more than half a centimetre in depth in which the lower part of the tumor was imbedded. The bone itself, with the exception of this depression, was normal; there was no hyperostosis around the depression, or any where else.

The tumor was found to be a cyst, both dermoid and sebaceous. Inside the part bordering on and attached to the indentation of the bone, there is a small bundle of minute hair. The microscope shows fat globules in large quantities and cholestearine crystals.

The locality of the tumor, and its contents, prove its dermoid character. It having been observed a very few months after birth, when it was quite small, and the depression of the bone, prove that it existed at an early time. There can hardly be a doubt that the duplicature of the ectoderm forming the cyst was of early foetal nature. It is probable that where the tumor was formed ossification remained incomplete and the bone thin. In a case of Heurtaux's, in which the development of the tumor became rapid about the thirtieth year of the patient, there was no ossification at all. In most other respects the description of my case is identical, to a great extent, with all those reported. In a case of Giraldés, and in one of Arnott, there was the same apparent pulsation which I described above. In a few cases the bone was found very thin, either by absorption or by deficient ossification; in a few others there was a hyperostosis round the point of attachment in the periosteum.

The diagnosis from encephalocele, or from meningocele, may be doubtful in occasional cases. The scarcity of the former over the centre of the fontanelle should not be claimed as a diagnostic point, for cases like that described above are also rare. A meningocele fluctuates, is very transparent (but possibly may, when small, be covered by skin), hairless, and compressible;

its contents can be forced back into the cranium, and may thus give rise to cerebral symptoms. Traumatic "spurious" meningocele need not give rise to cerebral symptoms, may not be (rarely is) reducible, and is covered by normal skin. When very small, it may give rise to doubts, and in some cases, when the question of an operation is raised, it will not do to be rash.

The contents are not always of the same consistency. Some contain, with the usual contents, a serum rich in sodium chloride.

A case of Sibthorpe and Hardy was not exactly over the centre of the fontanelle.

The number of cases of dermoid of the large fontanelle which have been reported is small. The first case, by Heldea (1770), was quoted by Wernher, who took these tumors to be strangled meningoceles. Picard related one in 1840; it was as large as a fist, and was observed on a woman of sixty years. Hewitt collected five cases, Giraldés fourteen. The best article on the subject known to me is that by Lannelongue and Ménard, in their "malformations de la tête et du cou."

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