

## The 4th English Medical Conference Yamaguchi University School of Medicine

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### 1) Cerebellar ataxia (Movie demonstration)

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Vertigo will occur due to disorder of any of the following structure: such as 1) cerebral cortex, 2) ocular muscles, 3) cerebellum, 4) labyrinthine apparatus, and 5) brain stem.

Lesion in the cerebellum and the brain stem oftenly produced peculiar ataxia, so-called cerebellar ataxia, and significantly pathologic nystagmus.

Movie demonstrated here consisted of: 1) Brief history of the patient who was 7 years-old male with the complaints of severe headache, projectile vomit, ataxia, and tinnitus. 2) Physical examination. 3) Laboratory findings. 4) X-ray film studies of the skull. 5) Vestibular function tests: In this part, characteristic cerebellar gait (wide base, unsteadiness, irregularity and lateral reeling) and peculiar spontaneous nystagmus including vertical nystagmus are well demonstrated. And 6) Autopsy finding and histopathologic finding (medulloblastoma). Conclusively, ataxia and nystagmus interpret many thing in a case with vertigo.

### 2) A Case of Neurilemmoma in the Neck

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A neurilemmoma in the neck in a 38-year-old female was presented. The patient was admitted to our clinic with the chief complaint of an asymptomatic mass on the left side of the neck of five-year duration. Cervical examination revealed an 8 by 5.5cm, smooth, soft, nonnodular mass involving the almost entire left neck. Preoperative diagnosis was salivary gland tumor. This mass was excised with no complication. Histological examination disclosed the mass to be a neurilemmoma.

### 3) Fistula Symptom of the Labyrinth

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The labyrinthine fistula test is used to determine whether the existence of the fistula through the semicircular canals and the ampulla or not. This can be usually accomplished by using a Politzer bag fitted with a tip which fits snugly into the orifice of the external acoustic canal.

In our clinic, recently, continuous pressure method have been studying to detect any latent fistula in the labyrinth, although we had used Politzer bag previously. We experienced cases with chronic otitis media, who showed positive sign by the continuous pressure fistula test though who showed negative by the ordinary fistula test and had a fistula at the horizontal semicircular canal which was revealed in the ear operation.

Two case with the labyrinthine fistula were presented in detail.

### 4) Sudden Change of Blood Group in Leukemia

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A case of ABO blood group change in leukemia was presented. The patient was a fifteen-year-old girl with acute stem cell leukemia (granulocytic) whose red cells had been typed as A without difficulty or any remark two years ago. The red cells of this patient were indistinguishable from normal type O cells by agglutination tests with anti-A, anti-B and most type O serums. However, after exposure to type B or type O serum, her red cells did eluate anti-A or anti-A+B ("anti-C") agglutinines respectively, though they absorbed a relatively small amount of these agglutinines. The cells were very weakly agglutinated by anti-H lectin (*Ulex europaeus*) in contrast to very strong agglutination of normal type O cells. The patient secreted abundance of type A substance in her saliva. No (or very feeble) anti-A agglutinine was demonstrable in her serum. From these findings we concluded that the red cell type of our patient had changed from ordinary A to a variant of "weak A" presumably as a result of leukemia.

## 5) Acid-Base Imbalance in Respiratory Diseases in Infancy and Childhood

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Arterial or capillary blood-gas and pH changes were studied in 58 children admitted in our hospital, between Aug. 1'66 and May 31'67 with acute bronchiolitis and bronchial asthma. The results obtained are as follow :

1) The relation between arterial  $P_{O_2}$  and  $P_{CO_2}$  on admission, when breathing air, was showed in such formula as  $P_{O_2}$  (mm. Hg.) =  $-1.34 \times P_{CO_2}$  (mm. Hg.) + 114.60 ( $\pm 18.19$ ),  $r = -0.80$ .

2) In the cases with acute bronchiolitis  $P_{CO_2}$  levels were within normal limit or rather decreased except for a few cases and base excesses showed almost negative, which might be derived rather from metabolic elements than respiratory even in respiratory distress. However, in the cases with bronchial asthma  $P_{CO_2}$  levels were increased in a half and base-deficit, if present, were not so remarkable.

3) About a half cases with acute bronchiolitis showed acidosis accompanied with base-deficit and another half was normal in pH. In asthma group pH levels were divided in three types, that is, acidosis with both high  $P_{CO_2}$  and base-deficit, within normal limit, and alkalosis with low  $P_{CO_2}$ .

4) Almost all cases in respiratory distress with cyanosis showed acidosis accompanied with base-deficit, the increase of which was of grave prognostic importance. Cyanosis, which was usually present when oxygen saturation was below 85%, was the most precise clinical sign of hypoxia.

5) Disturbance of both  $P_{CO_2}$  and buffer base approached toward normal limit, correlating with clinical improvement. Deviation apart from their normal levels during the course may be suggestive of taking a serious turn in prognosis.