
Giant intracranial aneurysms pose a rare but difficult surgical problem; Mullan of Chicago described their obliteration by inserting fine copper alloy wires to produce intra-aneurysmal thrombosis. We have used the technique in nine cases; five internal carotid, one middle cerebral, and one anterior communicating aneurysm, and two carotico-cavernous fistulas. Seven presented as space-occupying lesions, and two had subarachnoid haemorrhages. One of the latter died due to post-operative spasm and another from a perforated duodenal ulcer, but all the others improved following the procedure, and their proptosis and cranial nerve palsies resolved. None has bled from a treated aneurysm, and post-operative angiography has shown a marked reduction in aneurysmal lumen. In one patient we have successfully removed the bulk of the clot. Details of the technique were described.


Post-traumatic rhinorrhoea is well-known to neurosurgeons, although the indications for, and the timing of operative repair may be subject to individual preference or experience. The spontaneous or non-traumatic variety of rhinorrhoea is much less common, and in the first instance may present to the physician or otolaryngologist as a “rhinitis” or a “running nose”.

Little has been written on the subject of spontaneous rhinorrhoea with the exception of excellent contributions by O’Connell (1964) and Ommaya (1968). The classification proposed at that time by Ommaya has the advantage of simplicity but it is not entirely satisfactory. The present paper reviews the salient clinical features of spontaneous rhinorrhoea in a personal series of 10 cases and several others referred by colleagues, and annotates the high pressure variety, the tendency to copious flow, and the much lower incidence of meningitis in these cases than in the traumatic group.

Recent methods of investigation are examined.

The spontaneous variety always requires operative closure.

The proposition is made that some of the low pressure spontaneous leaks are in fact delayed-onset traumatic cases, and a numerically small but important variety following long-standing chronic rhinitis with atrophy of the olfactory
bulb and filaments is described. Because of the rarity of the condition case numbers are small and these are propositions to be further considered rather than conclusions. Nonetheless, it is important to recognise these cases and to close the fistulas.

Galbraith, S., Teasdale, G., Jennett, B. (Glasgow): The Results of Conservative Management of Acute Traumatic Intradural Haematoma.

Since the introduction of computer tomography it has become apparent that haematomas can be present in patients who are not clinically deteriorating. Because the natural history of these haematomas was not known we have studied 17 patients to determine how often operation was required and whether this could be predicted.

Only 6 (35%) patients eventually required operation, and of those managed conservatively 9 made a good recovery, 1 remained severely disabled, and 1 died. Patients who were not in coma and had no midline shift did not require operation; other than this, age, midline shift, intracranial pressure, and level of responsiveness were unhelpful in predicting the need for surgery. The implications of these findings were discussed.


All patients with extradural haematomas treated in the Edinburgh area over two separate decades (1951–1960 and 1968–1977) were analysed to assess the effect of delay on morbidity and mortality. A total of 145 cases were treated surgically, and of these 50 were associated with subdural haematoma or brain contusion or both. Only extradural haematomas of greater than 1.5 cm in thickness were included in the present study (83). Five posterior fossa haematoma were encountered. In seven patients time intervals were inadequately documented, and they were therefore excluded. The results of the study are summarized in the table below:

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<tr>
<td>Number of cases</td>
<td>27</td>
<td>56</td>
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<tr>
<td>Mean delay from deterioration in consciousness to start of operation</td>
<td>8.0 (hours)</td>
<td>1.4 (hours)</td>
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<tr>
<td>Good recovery</td>
<td>40.7%</td>
<td>67.9%</td>
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<tr>
<td>Mortality</td>
<td>33.3%</td>
<td>8.9%</td>
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Detailed analysis of the delay from deterioration in level of consciousness to definitive operation showed that a delay of more than 2 hours resulted in increased morbidity and mortality in both groups. The policy of immediate admission of all head injuries for at least 24 hours to the head and spinal injuries unit of the Department of Surgical Neurology was not instituted until after 1960. The improved results in the 1968–1977 period suggest that this policy is advantageous because of the earlier surgical intervention that was possible.