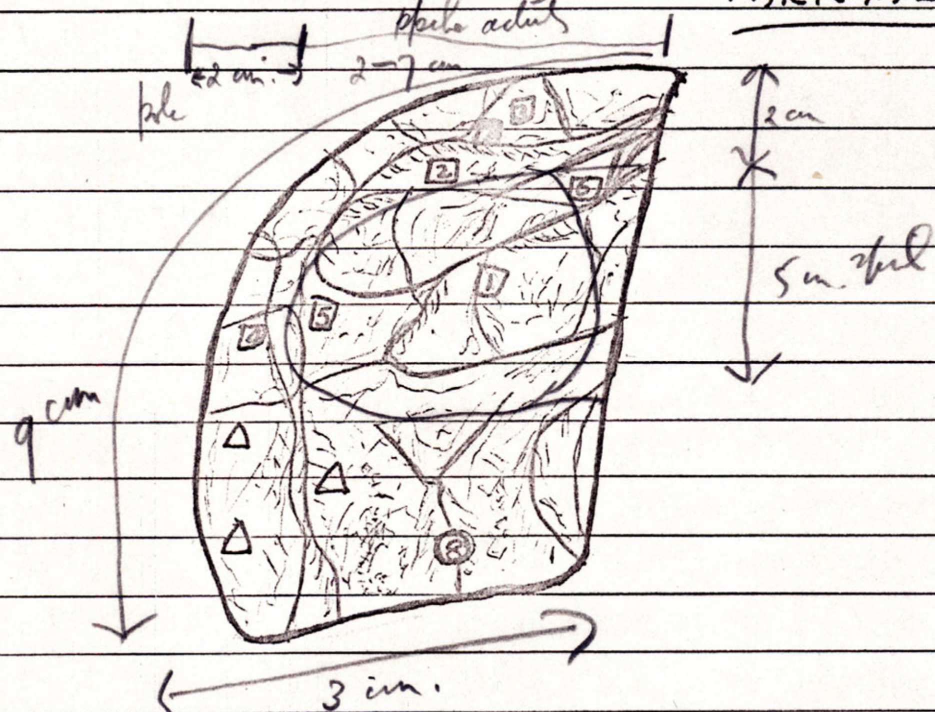
CONTINUATION SHEET

CLINIC

OLDCHURCH HOSPITAL, ROMFORD

SURNAME (*Block Letters*) FIRST NAMES RECORD NUMBER

DATE	NOTES AND PROGRESS
8/12/67	-(L) POSTERIOR FRONTO PARIETAL FLAP



[1] 3 cm from mid line; 4.5 cm post. to frontal pole
[2] 5 cm " " " ; 3.0 " " " "
[3] 4.5 " " " " ; 1.5 " " " "
[4] 6.5 " " " " ; 5.0 " " " "
[5] 5.0 " " " " ; 4.5 " " " "
nil in post. lat. part ← [6] 2.0 " " " " ; 3.0 " " " "
[7] 4.0 " " " " 2.0 " " " "
(8) 3.5 " " " " 9.0 " " " "

△ - 3 volts for 10 seconds caused [(not true spike)
twitching of contralateral face only

CONTINUATION SHEET

CLINIC

OLDCHURCH HOSPITAL, ROMFORD

Ward E.3.

SURNAME (*Block Letters*) FIRST NAMES

RECORD NUMBER

Mrs.

DATE	NOTES AND PROGRESS
8.12.67.	Craniotomy with electro-corticography.
	Local anaesthesia Surgeon : Mr. John Andrew.
	A left fronto-parietal flap was marked out extending so that the anterior limb of the incision was at the hair line, and then it extended to the midline 4 cms. behind the coronal suture, and then posteriorly to above the ear.
	1% xylocaine. Bone rather thickened and adherent to the underlying dura. Flap cut after making 6 burr holes, and the dura was torn in 2 places. Because of the low tension, the dura was hitched to the pericraneum at once. Dura now opened.
	The frontal lobe was exposed so that we could just see the frontal pole to a distance of about 14 cms. posterior to it, and to the mid-line and to within 2 cms. from the pterion.
	Electro-corticography: The exposed area and the medial surface of the frontal lobe were explored, and the predetermined spike activity was in an area between 2 cms. and 7 cms. posterior to the pole and within 2 cms. down 5 cms. from the midline. There was however, no visible abnormality on the surface of the brain.
	More posteriorly now, the face area was found by stimulation with up to 3 volts using a single pole electrode.
	The line of lobectomy was marked out 2 cms. anterior to the motor cortex delineated and to 1½ cms. beyond the area of maximum spike activity.

continued/.....

DATE	NOTES and PROGRESS
	A rather wedge shaped frontal lobectomy was now performed to include superiorly and anteriorly part of the middle convolution by leaving behind the cingulate gyrus and the frontal operculum.
	The ventricle was not entered.
	From the frontal pole the cortex superiorly excised was 9 cms. long and on the orbital surface 3 cms. The olfactory tract was not seen.
	Haemostasis.
	Dural closure.
	Bone flap replaced with Poppen stitch.
	Scalp flap closed in 2 layers with Steripac.
JA/VW.	

REPORT ON ELECTROPHYSIOLOGICAL EXAMINATION

E.E.G. and sphenoidal leads

E.E.G. No. 1238
Date of Test : 30.11.67

Patient's Surname :	Christian Names :	Age :	Record No :
		36	

To :
Mr. Andrew,
E 3 Ward,
Oldchurch Hospital,
Romford.

From :
Consultant in Charge,
E.E.G. Department,
Oldchurch Hospital,
Romford, Essex.

Tel : ROM 46090
Ward : C.2.

CLINICAL HISTORY :

Please let me know if this summary is inadequate or erroneous in any important respect as this may have a bearing on the interpretation of the record.

Epilepsy since shildhood. Grand mal, petit mal plus other attacks preceded by giddiness and palpitation.

REPORT :

Date :

This record shows alpha rhythm at 7 - 8 c/s which is normally responsive to eye opening. The striking feature consists of continuous 3 - 4 c/s slow waves on each of which a spike discharge is superimposed. These complexes arise at the left anterior parasagittal electrode or possibly just in front of it. They are unaffected by eye opening or by mental concentration (counting out loud). Slow activity which is recordable from the right anterior quadrant is probably conducted there from the left side. Hyperventilation was carried out well for 3 minutes but did not produce any change.

Conclusion:

The record is essentially similar to those of 19.10.67 and 3.11.67 taken at Severalls Hospital and with which the present E.E.G. has been compared. It is also similar to records taken several times since 1958, judging from the reports of these. There is an epileptic focus on the upper convexity of the left frontal lobe.

N. de M. Rudolf

N. de M. Rudolf,
Locum Consultant in Charge.

REPORT ON ELECTROPHYSIOLOGICAL EXAMINATION

E.E.G.

E.E.G. No. 1254
Date of Test : 5.12.67.

Patient's Surname :	Christian Names :	Age :	Record No :
		36	

To : Mr. Andrew
Ward E.3.

From :
Consultant in Charge,
E.E.G. Department,
Oldchurch Hospital,
Romford, Essex.

Tel : ROM 46090
Ward : C.2.

CLINICAL HISTORY :

Please let me know if this summary is inadequate or erroneous in any important respect as this may have a bearing on the interpretation of the record.

REPORT : Date :

A further record was taken with the aim of studying the location of the spike discharge more intensively. The first part of the recording is similar to that described on 30.11.67. First ~~xx~~ it was shown that, the eyes being open, fist clenching, either right or left, had no effect on the repeatedly ~~fouling~~ firing spike discharge in the left frontal area.

An attack occured spontaneously which was heralded by fast activity at about 18 cycles per second which increased in amplitude over about 3 seconds, and then died away over a further few seconds with some increase in frequency. This was mainly confined to the left frontal region. By the time movements began the E.E.G. was in most channels of low amplitude and the fast activity had practically disappeared. The head and body then twisted to the left and there was writhing of all limbs, the eyes being open. During the movements there was some slow activity, but this may not be genuine. Then when the movements are stopping some alpha rhythm reappeared, and after some seconds the patient becomes responsive. The E.E.G. then shows 8 to 8.5 cycles per second alpha rhythm symmetrically, like that seen previously, but with slightly lower voltage. Strikingly there is a complete absence of the focal disturbance on the left and there is no significant slow activity. This period of normality lasts for 2 minutes, and then very small spikes appear in the left frontal region at 3 to 4 cyles per second and are uninfluenced by eye opening or closing. Over the next four minutes there is a very gradual increase in amplitude of these spikes, but during this time the patient is apparently becoming drowsy, with the appearance of some low voltage bilateral frontal fast activity and intermittent disappearance of the alpha rhythm. At this stage auditory stimulation brings back the alpha rhythm, but does not affect the spikes. In the following period the frequency of the spike discharges decreases and they become less regular in occurence and after a further three minutes they are occuring as rarely as about 1 in 10 seconds and are very small; at this stage the patient is asleep

/and

and there is some scattered theta activity and ~~the~~ alpha rhythm. At this stage Auditory stimulation evokes some fast activity bilaterally, but does not influence the spikes. Following this sleep spindles appeared which varied from side to side, but on the whole are not asymmetrical. The patient was then woken up and the alpha appeared and immediately the spikes became more frequent, and over about 10 seconds returned to the original frequency of 3 to 4 seconds. It was then about 8 minutes after the attack. The amplitude of the spikes, however, is not as great as originally. The patient then becomes drowsy again with similar electrical accompaniments and on rousing her the spikes revert to the waking frequency. The patient was then kept awake and the spike discharges gradually increased in amplitude reaching the original level after at least 10 minutes from the time of the attack.

Another attack occured in which the head turned to the right; recording just after the beginning of it showed 16 cycles rhythmic fast activity maximal in the left frontal region, but seen throughout both hemispheres which over a few seconds slowed to about 8 cycles per second and was then replaced by some diffuse rhythm at about 4 cycles per second. This is soon replaced by an E.E.G. which shows only alpha rhythm bilaterally. Spike discharges reappear and increase in frequency from 2 and ½ minutes after the attack.

Electrode 6 (the anterior parasagittal electrode on the left) was then moved to several positions in front of or behind the normal position. The results of this and of using various electrode montages indicates that the spikes are recorded with highest amplitude a little in front of electrode 6, the position of which was 6 centimetres to the left of the midline and 7 centimetres posterior to the superior orbital margin (middle part) measured along the scalp. This would put the maximum of the spike discharge 6 centimetres from the mid-line, about 5½ centimetres back from the superior orbital margin. One further attack occured but was not recorded in which the head was turned to the left.

It is noted that in the present record there is some low voltage frontal fast activity when the patient is alert which is much less evident on the left than the right, and this presumably represents depression of function on the left. This activity was not so evident on the previous record. The difference may be due to the change in medication since then.

N. de M. Rudolf,
Locum Consultant in Charge.

REPORT ON ELECTROPHYSIOLOGICAL EXAMINATION

E.E.G.

E.E.G. No. 1326/3/1274
Date of Test : 27.12.67

Patient's Surname :	Christian Names :	Age :	Record No :
		36	181153

To :

Mr. Andrew,
E 3 Ward,
Oldchurch Hospital,
Romford.

From :

Consultant in Charge,
E.E.G. Department,
Oldchurch Hospital,
Romford, Essex.

Tel : ROM 46090
Ward : C.2.

CLINICAL HISTORY :

Please let me know if this summary is inadequate or erroneous in any important respect as this may have a bearing on the interpretation of the record.

18 days post-op.
No further attacks.

REPORT :

Date :

This record was taken on the 18th post-operative day and shows a 7 - 8 c/s "alpha" rhythm which is blocked by opening the eyes and at times has a slightly higher amplitude on the left side than the right. There is some random delta activity of rather low voltage in all areas and not more conspicuous in the left anterior quadrant than anywhere else. Near the vertex there is some 7 - 8 c/s activity of low voltage which is not blocked by opening the eyes and this may represent some mu activity.

Conclusion:

There is no evidence of any epileptic activity.

N. de M. Rudolf,
Locum Consultant in Charge.

REPORT ON ELECTROPHYSIOLOGICAL EXAMINATION

E.E.G.

E.E.G. No. 431/4/1326
Date of Test : 16.4.68

	Patient's Surname :	Christian Names :	Age :	Record No :
			36	181153

To :

Mr. Andrew,
Oldchurch Hospital.

From :

Consultant in Charge,
E.E.G. Department,
Oldchurch Hospital,
Romford, Essex.

Tel : ROM 46090
Ward : C.2.

CLINICAL HISTORY :

Please let me know if this summary is inadequate or erroneous in any important respect as this may have a bearing on the interpretation of the record.

Having phenobarbitone spansules and ospilot.
No epilepsy since craniotomy last November.

REPORT :

Date :

The patient appeared a little more alert on this occasion.

The record still shows the dominant rhythm at 7 - 8 c/s, but the random delta activity is less evident. The mu like rhythm is still present. Responses to overbreathing and photic stimulation are normal.

Conclusion:

There is still no evidence of epileptic activity.

N. de M. Rudolf

HOSP. FORM. E.E.G.2.

ST. HELENA GROUP HOSPITAL MANAGEMENT COMMITTEE, COLCHESTER

(North-East Metropolitan Regional Hospital Board)

Chairman: H. Hepburn Reid, M.B.E., J.P.

Group Secretary: Charles A. Merrick, F.H.A.

Hospital Secretary:
J. P. Watson
Telephone: Colchester 77271

Your Ref.:
Our Ref.: RF/CRP

SEVERALLS HOSPITAL
COLCHESTER
ESSEX

DR. RICHARD FOX'S UNIT.

19th January, 1968.

Dear Dr. Paros,

re: Mrs. , aet 36,
13, Avenue, , Essex.

I think you know some of the developments since my letter to you of September 26th concerning Mrs. Jervis' admission which was on October 11th.

She continued tense, giddy, considerably retarded to the point where her thought processes almost siezed up at times, and with occasional epileptic fits, after one of which she required three stitches in her head. Two more E.E.Gs. confirmed the consistent left frontal spike and wave complex and so we transferred her in the middle of November to Chelmsford Hospital for consideration of surgery. Her generally deteriorated state made us fear that the spike focus was but part of a generalised atrophy, but ~~that~~ the A.E.G. showed reasonably normal ventricles with normal angiography, and so on December 8th the supero-lateral part of the left frontal lobe was excised at Oldchurch Hospital. She had traumatic meningitis which cleared quite quickly and she was transferred back here on December 30th.

There have been no fits at all since the operation, and she has improved quite strikingly in personality and spontaneity although she is not everyone's ideal party companion. An E.E.G. on January 3rd showed a dramatic improvement with a faster alpha rhythm though it is still a bit slow, and complete absence of spike and wave complexes for the first time ever. We shall need to maintain anticonvulsants and keep our fingers crossed for some time yet, but so far we have an excellent result. Serum folate, incidentally, was low and so her improvement in personality may be partly related to our giving folic acid, though the role of folic acid in the deterioration of chronic epilepsy is somewhat in the melting pot at the moment as I am sure you know.

The next point is that I have just heard from the neurosurgeon that preliminary reports on the excised brain suggest tuberous sclerosis. An isolated sclerotic lesion like this is very unusual indeed, but there is a suggested family history. Mother, was in mental hospital several times in Göttingen and a maternal aunt had fits similar to Mrs. s'. — about 15 years ago.

Mrs. has been increasingly restless all this month, fed up with having been in hospital since October, and she does seem so well that I finally agreed to her going home on January 18th. I have had a final blood work up which I may append to this letter, but meanwhile drugs should be:

Ferro Gradumet 1 o.m.
Spans. Phenobarb. mgs. 100 b.d.
Ospolot tbs. 1 b.d.
Folic Acid mgs. 10 b.d.

I shall see her in the E.C.H. outpatients shortly, and the neurosuregons want to see her again in about two months.

And so, back to the social services. Foster parents are said to want to send back her little boy, but she feels unready yet to take him, and I have instructed her under no circumstances to take him back until the beginning of next month at the earliest. I leave it to you and our various colleagues in the social services listed below to decide when she is fit to have this child and I suppose there is a possibility husband might return now that she is so much better. Certainly, somebody ought to tell him what has been going on if he doesn't know already.

Dr. N. Paros,
272a Mersea Road,
Colchester.

Richard Fox,
M.B., M.R.C.P., D.P.M.,
Consultant Psychiatrist.

c.c. Mr. Ivan Hazel,
Mental Welfare Dept.,

Mrs. Footner,
Health Visitor

Mr. Whittle,
Children's Dept.,

Dr. Ann Clarke,
Medical Officer,

Mrs. Cook
Housing Dept.,

Ministry of Social Security,

Mr. Standley,
Marshall & Sutton,
Solicitors

Mr. John Andrew
Neurosurgeon.

Dr. F. Lees,
Consultant Neurologist.