



Brain Abscess

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I. CASE REPORTS

1. CHRONIC EMPYEMA. BRAIN ABSCESS.

Case is of white female, 25 years old, who had appendectomy performed on 11- -33 following which she developed pneumonia and left empyema. Rib resection and open thoracotomy done and for 5 months prior to admission (4-24-34), she had a drain in left chest. On admission, physical findings showed draining sinus in left chest and diminished breath sounds over left chest. X-ray showed empyema on left side with hydropneumothorax. Treated for empyema and discharged 7- 4-34 with instructions to return for reexamination.

Interval history: Had considerable pain and diffuse drainage from chest.

8-8-34 - Readmitted.

8-27-34 - White blood count - 12,500.

9-19-34 - Empyema cavity unroofed.

9-25-34 - Thick and purulent drainage from chest.

9-29-34 - Feels numb all over and has difficulty in speaking. Had convulsion which lasted 5 minutes.

10-3-34 - Neurological examination: Speaks slowly and has difficulty in expressing herself. Paresis present of lower right facial muscles. During examination, patient had typical Jacksonian convulsion, beginning in corner of mouth on right side and spreading to arm, leg and then to opposite side following which she lost consciousness. Opinion: Lesion in left motor area. Suggest x-ray of skull and spinal puncture; exploration indicated although lesions may be multiple.

10-4-34 - Neurological note: deep reflexes decreased on right side. If general condition permits, exploration is indicated.

10-17-34 - Spinal fluid - pressure 200 mm. of water; culture negative; no cells. Protein test negative.

Hemorrhages

11-9-34 - Right eye ground - moderate papilloedema with engorgement of veins and numerous small flame-shaped hemorrhages surrounding disc; left eye - similar picture in milder degree shown. Impression: more apt to be optic neuritis than choked disc from intracranial pressure.

11-10-34 - Breathing labored.

11-12-34 - Lethargic.

11-14-34 - Pulse rapid and thready.

11-15-34 - Expired.

Autopsy

Limited to head.

Meninges show no hemorrhage or exudate. Discolored, firm area of brain tissue present in left parietal region. This is incised and about 150 cc. thick, greenish, foul-smelling pus escapes. There is a tough capsule and the cavity is about 8 cm. in diameter. Ventricles are not distended but the abscess has indented the mid-part of left lateral ventricle. Capsule is easily removed in entirety from rest of brain tissue. No large vessels seen coursing from brain tissue to abscess wall proper. No hemorrhages or abscesses seen in rest of brain.

Microscopic of capsule, stained with azocarmine, shows a dense connective tissue wall (courtesy of Dr. Baker). Smear showed no organism.

2. RIGHT TEMPORAL LOBE ABSCESS. CHRONIC SUPPURATIVE OTITIS MEDIA, RIGHT. CHRONIC SUPPURATIVE MASTOIDITIS.

Case is that of white male, 17 years of age, admitted to University Hospitals 7-13-31 and expired 7-15-31.

1917 (age 4) - Had scarlet fever following which he had discharge from both ears.

1918 - Left mastoidectomy performed

and ear on that side stopped draining.

8-24-27 (OPD) - Tympanic membrane of right ear destroyed. Small amount of secretion present.

8-6-30 - (OPD) - Discharge from right ear and almost total deafness.

8-25-30 - (OPD) - X-ray - right chronic sclerotic mastoiditis.

7-11-31 - (OPD) - Complains of pain in front of right ear and over right forehead. Profuse purulent discharge. Drum red. Temperature 99.4, pulse 128, respirations 30.

Admitted

7-13-31 - Complaints: right frontal headache, earache (right side), discharge (right ear). Past history: About 5 months before admission, discharge from right ear became more profuse. Pain became more constant and was localized in right temporal, frontal and zygomatic regions. For 2 days before admission, had vomiting spells. Physical examination: slight tenderness over right mastoid; blood pressure 120/86. Laboratory: Blood - hemoglobin 81%, leucocytes 14,450, neutrophils 83%.

Neurologic Consultation

7-14-31 - Neurologic consultation: Attention difficult to hold. There is horizontal nystagmus. Slight redness of both optic discs. Uniformly decreased deep reflexes. None of these findings would serve to localize any intracranial pathology. Spinal puncture - fluid cloudy, 350 cells, pressure 300 mm. water, Noguchi +. Patient has stiff neck and a suggestive Kernig sign. This indicates a severe meningeal reaction.

7-15-31 - Respirations very slow and irregular, at times suggesting Cheyne-Stokes type. Spinal puncture - 3050 cells, fluid cloudy. Temperature 105.6.

7-16-31 - Spinal fluid - gram + diplococci. 12:20 P.M. - Expired suddenly (apparent respiratory failure).

Autopsy: Abstract.

Findings: There is injection of the pia arachnoid in the middle cranial fossa.

There is a large abscess near the surface of the right temporal lobe extending into the substance and communicating with the right lateral ventricle. There is pus in both ventricles.

3. MASTOIDITIS, RIGHT. BRAIN ABSCESS, RIGHT TEMPORAL REGION.

Case is of 13 year old, white female admitted 10-17-31 and discharged 2-15-32.

Past history

1926 - First had earache and discharge from right ear.

7- -31 - Developed a middle ear infection. Ear drained from this time until 3 weeks before admission when the drainage ceased and patient developed pain behind right ear. During 2 weeks before admission, patient vomited daily.

10-14-31 - (3 days before admission) - Had a spell of unconsciousness. Had diplopia since this time.

Admitted

10-17-31 - Physical examination: bilateral choked disc; right drum shows a large central perforation from which there issued a scanty serous discharge. X-ray shows chronic mastoiditis on right. Mastoidectomy done.

10-20-31 - Neurologic consultation: Impression - superior temporal or temporo-parietal abscess. Advise: spinal puncture. Spinal fluid - clear, no cells, pressure 350 mm. of water, culture negative. Following mastoidectomy, patient improved somewhat until November 11, 1931 when she again had headache and vomiting which became progressively worse.

Operation

11-15-31 - Mastoid reopened through old incision. Sinus and middle fossa found to be in healthy condition. Posterior bony canal and external attic wall completely removed. Dura over antrum and attic region found to be dark blue and somewhat necrotic. Probe readily passed through this area. Dura placed

up with hooks and incised. Brain trochar introduced to depth of 2.5 cm. Slight resistance was met through which the trochar was easily pushed. About 1 oz. of pus was evacuated. Trochar was withdrawn and a small rubber catheter was inserted into the abscess cavity. Cavity was then gently packed with iodoform gauze. Postoperatively, patient made a slow but steady gain.

2-15-32 - Discharged in good condition.

4. LEFT FRONTAL SINUSITIS. LEFT FRONTAL BRAIN ABSCESS.

Case is that of a white male, 12 years old, admitted to University Hospitals 10-24-31 and expired 10-31-31.

9-10-31 - Went swimming. Shortly thereafter, complained of pain in left frontal region over eye.

10-1-31 - Appetite poor. Vomits occasionally.

10-17-31 - For past week, patient has vomited more frequently and headache has been more severe. At times, it radiates to back of head.

10-20-31 - Complains of seeing double.

Admitted

10-24-31 - Physical examination: slight swelling over left eye; photophobia and tenderness of eyeball on left side; slight paresis of left external rectus. Laboratory: Blood - wbc's 10,850. Spinal fluid - clear and colorless, 5 cells. X-ray of skull and sinuses -negative.

10-25-31 - Temperature 99.2. Pulse 80. Cries because of pain in occipital region.

10-26-31 - Still has severe headache. Vomits after eating.

10-27-31 - Right arm twitches noticeably. Marked twitching of right arm and face before patient screams with pain. Pulse 62. Temperature 99. Suggestive of rigidity. Eye consultation: bilateral choked discs with hemorrhage.

Neurologic consultation

10-28-31 - Bilateral 6th nerve paralysis, bilateral choked disc. Deep reflexes all markedly reduced. Slight adiadokokinesis on left. Impression: brain tumor, possibly in 4th ventricle. Suggest ventriculogram.

10-29-31 - Drowsy.

10-31-31 - In critical condition. Breathing irregular. Ventriculography attempted. Condition worse. Placed in respirator. Expired.

Autopsy: Abstract.

Head: There is a left frontal abscess containing about 250 cc. of thick pus. Abscess has ruptured into the left lateral ventricle. Direct erosion of bone through wall of left frontal sinus.

5. FRACTURE OF SKULL IN LEFT FRONTAL SINUS. BRAIN ABSCESS. MENINGITIS.

Case is of white male, 22 years of age, admitted to University Hospitals 9-6-31 and expired 9-8-31.

8-16-31 - Injured head and right shoulder in automobile accident. Unconscious for about one hour. Some bleeding from mouth but none from ears. Continued being up and about but complained of fairly constant dull headache.

9-5-31 - Complained of stiffness of neck and experienced vomiting.

Admitted

9-6-31 - Physical examination: Patient is delirious and uncontrollable. Marked neck rigidity. Fluctuant area over left frontal region. Discs appear somewhat reddened. Babinski positive on right. Spinal fluid - cloudy, 12,000 cells; smear shows gram+ cocci. Following a bout of violence, patient became unconscious.

9-7-31 - Now extremely restless. Restraints applied.

9-8-31 - Cyanotic. Cheyne-Stokes respirations. Expired.

Note by Neurological Staff: Patient was in hospital only one hour after his automobile accident.

Autopsy: Abstract

Head: Fracture of left frontal bone. Meningitis. Brain over left frontal sinus shows definite necrosis formation with very little walling off. There are few punctate hemorrhages throughout the brain. The frontal sinus has been fractured and communicates with the intracranial cavity.

II. ABSTRACTS

1. Macewen, Wm.
PYOGENIC DISEASES OF THE BRAIN AND SPINAL CORD, 1893.

Statistical Table of Intracranial Abscess.

<u>Disease</u>	<u>No. of Cases</u>	<u>No. Operated on</u>	<u>No. Cured</u>	<u>No. Died</u>
Cerebral abscess--				
In temporo-sphenoidal lobe	10	9	8	2
In frontal lobe	2	1	1	1
In parietal lobe	1	1	1	0
Superficial (Ulceration of brain)	4	4	4	0
Cerebellar abscess	8	4	4	4
Total	<u>25</u>	<u>19</u>	<u>18</u>	<u>7</u>
Extradural abscess	5	5	5	0
Total	<u>50</u>	<u>34</u>	<u>23</u>	<u>7</u>

For drainage, in some instances, the author employed an absorbable decalcified chicken-bone tube which was introduced into the abscess cavity and stitched to the skin so as to retain it in position. The inner margin of the tube was made to project just within the outer wall of the abscess cavity.

2. Grant, F. C.
THE MORTALITY FROM ABSCESS OF THE BRAIN.
J.A.M.A. 99, 7: 550, (Aug. 13,) '32.

Fifty-One Cases of Brain Abscess

Preoperative localization and diagnosis correct	39 or 76.4%
Cases diagnosed as tumor but localization correct	4
Total localization correct	43 or 84.3%

Time of Encapsulation

Operated on within 2 weeks	13
10 unencapsulated	
3 encapsulated	
Operated on third to fourth week	12
8 unencapsulated	
10 encapsulated	
Operated on fifth to sixth week	5
2 unencapsulated	
3 encapsulated	

It was the author's opinion "that thorough walling off of a subcortical area of infection within the brain requires about four weeks from the onset of symptoms, provided that the defensive mechanism of the brain is not overwhelmed from the start by the virulence of the infection."

Results of Fundiscopic Examination

13 Unencapsulated Abscesses

No choked disk	11
Blurred disk	2
Choked disk up to 5 diopters	5

50 Encapsulated Abscesses

No choked disk	8
In 2 of these abscesses present for at least a year and chocking may have subsided	
Blurring of disk	4
Choked disk up to 7 diopters	38

Of four patients with localized abscesses, operated on during the 6th week, all recovered. In this group are included two cerebellar abscesses that were simply evacuated and not drained. Both patients were alive and well four and two years later.

In a discussion of this paper, Dr. Ernest Sachs (St. Louis) tells of his experience with the aspiration of brain abscesses.

3. Kopetzky, S. J.
OTOLOGIC SURGERY,
2d Edition, 1929.

The author states as a result of the analysis of a large series of otitic brain abscesses that the temporo-sphenoidal lobe is the site of the abscess in approximately 65% of the cases. He quotes Neumann's statistics to show that the aural suppurations associated with cholesteatoma furnish the largest percentage of cerebellar abscesses. In destruction of the tegmen with an extradural collection of pus in the middle cranial fossa, the abscess is in all probability located in the temporosphenoidal lobe.

He produces the Neisser-Pollack diagram to indicate points for exploratory puncture in the location of brain abscess (Page 409).

4. Eagleton, W. P.
BRAIN ABSCESS
1922.

Cerebellar Abscess:

"In 117 recorded postmortems, the abscess was of otitic origin in 99 cases, from sphenoid sinus suppuration in 2, metastatic in 2, traumatic in 2, tuberculous in 2, carcinomatous in 1, and syphilitic in 1."

Frontal Lobe Abscess Analysis of 140 Reported Cases

I	Adjacent frontal lobe abscess		104
	From frontal sinus	63	
	From ethmoid	25	
	With orbital complications	41	
	Associated with osteomyelitis	9	
II	Metastatic frontal lobe abscess		14
	In opposite lobe	7	
	Of aural origin	9	
III	Traumatic frontal lobe abscess		<u>22</u>
			140

5. Atkinson, E. M.
HUNTERIAN LECTURE ON ABSCESS OF THE BRAIN; ITS PATHOLOGY, DIAGNOSIS AND TREATMENT.
Lancet 1: 485, 1928.

He points out that the blood supply of the brain comes from the circle of Willis by two types of vessels: (1) Central branches which pass directly into the base of the brain to supply the central nuclei and the main mass of white matter: (2) Cortical branches which pass over the surface and into the fissures, ultimately dividing them into two varieties of terminal branches.

(a) A larger number of short branches which supply the grey matter of the cortex only.

(b) A smaller number of longer branches which pass through the cortex to supply a thin layer of subjacent white matter.

He says that there is no anastomosis between the central and cortical vessels so that a relatively avascular zone is formed. It is in this zone that brain abscesses originate (otitic?).

In 13 of 16 cases of brain abscess of otitic origin studied by the author, he believes that the route of the infection was through the perivascular spaces. In 2 cases, he felt that this infection was by the venous route in the form of a retrograde thrombophlebitis. He felt that in one instance the route was by way of arterial thrombosis. In the cerebrum, the abscess increases at the expense of the white matter, the cortex by reason of its good blood supply being protected until quite late. In the cerebellum, the spread is at the expense of the white matter forming the core of the lobule. The central mass of white matter containing the central cerebellar nuclei is not usually involved to any great extent so that localizing signs may be absent. He groups as a triad suppurative labyrinthitis, extradural abscess and cerebellar abscess. If the labyrinth is not involved, the route of infection is through the posterior antral wall, either direct through Trautmann's triangle to the dura of the posterior fossa, or more commonly to the lateral sinus and thence to the cerebellum, in either case with or without the intermediate formation of an extradural abscess. He advocates lumbar puncture as a safe procedure and a valuable aid in early diagnosis of brain abscess. Any increase in pressure or in cell count with diminished percentage of chlorides will be valuable confirmatory evidence.

Route of Approach

He suggests that the approach be via the originating focus and states that the advantages are: (1) it deals with the source of the infection, (2) the track into the brain can be followed, if found, and drainage instituted through an area of subarachnoid space already shut off by adhesions, (3) any additional complication, such as an extradural abscess or lateral sinus thrombosis, will not be overlooked.

6. Dandy, Walter E.
PRACTICE OF SURGERY
 Dean Lewis (1932) xii, 365.

Lumbar punctures usually speed the progress of acute abscesses of the brain and, therefore, should be used only

when there is an urgent demand. The main principles in the treatment of a brain abscess are: (1) wait for encapsulation if possible, (2) avoid trauma to an already damaged brain, (3) avoid herniation.

The time for action is determined solely by the degree of intracranial pressure and not by signs due to the infection. The patient's general state of consciousness, bradycardia, degree of headaches and the eye grounds are the best guides to the degree of intracranial pressure. The author's method of treatment is simply to tap the abscess. Between one and four tappings are required.

Procedure

Through a cutaneous opening about 2 cm. in length, a small bony opening is made with a perforator. A stab is made into the dura with a fine pointed knife. The abscess is merely tapped, it is not aspirated nor irrigated. The puncture should always be directed away from the lateral ventricle and, of course, areas of brain with important functions should be avoided. Continuous drainage is not utilized in this procedure. Dr. Dandy feels that it is not possible to drain a subcortical abscess unless it is very large and very near the surface. For abscess with large cavities pushing against the dura and without interposed brain tissue, a small tube sutured to the dura and just entering the cavity is probably preferable for a few days. Tubes should not be deeply inserted into the abscess nor should irrigation be used. He uses ventriculography and ventricular estimation as an aid in the localization of brain abscess. If the localization of an abscess is suspected, the region is tapped before resorting to ventriculography.

If a fistulous tract is found during the exploration of an extradural abscess, slight dilatation may cure the cerebral abscess but there is danger of opening intact cortex and spreading infection. Dr. Dandy prefers to tap over a clean territory unless pus is spontaneously evacuated when the dura is exposed.

7. Southard, E. E.
Osler V: 378, 1915.

Persistent high temperature or intermittent fever is not characteristic. Generalized convulsions occur in a minority of cases. Episodic attacks of restlessness, confusion or excitement are common. In temporal lobe lesions, one should examine for spastic hemiparesis, hemi-anesthesia and hemianopsia. If the left temporal lobe is involved in right-handed persons, one should examine for sensory aphasia. Paralytic phenomena are probably due to internal capsule involvement.

Temporal lobe abscess is about twice as frequent as cerebellar abscess following ear disease. (Heimann - 428 temporal, 198 cerebellar. Neumann - 336 temporal, 196 cerebellar.)

Dench reviewed 102 cases of cerebellar abscess. There were 33 recoveries. In 100 cases of cerebral abscess of otitic origin, there were 52 recoveries. Gerber collected from the literature 66 cases of brain abscess following frontal sinus disease. In the majority of cases, the posterior wall of the sinus was diseased. The abscesses are usually found involving the gyri of the orbital surfaces. "If after frontal sinus operation, the headaches continue or increase and alteration of general attitude, slowness of speech, restlessness alternating with apathy, brain abscess is to be suspected.

Metastatic abscesses are not seldom single and warrant operation.

8. Oxford Medicine VI:
Chap. IV, P. 85.

A middle ear suppuration is liable to lead to temporosphenoidal abscess, whilst the cerebellar situation more frequently follows mastoid infection. The headache in brain abscess is apt to be of the congestive variety, the pain being increased by stooping or straining. In uncomplicated cases, the white count varies between 10,000 and 12,000. In a St. Bartholomew's series of 48 cases of brain abscess of otitic

origin, there were 10 recoveries. In 15 brain abscesses from other sources, all died. A high white count in the spinal fluid is not an absolute contra-indication to operation.

9. Oppenheim
DISEASES OF THE NERVOUS SYSTEM
P. 547.

Metastatic form of brain abscess favors the region supplied by the middle cerebral artery. Records 76 cases of brain abscess of otitic origin. All were on the same side as the ear infection.

Temporal lobe	55
Cerebellum	13
Cerebrum and cerebellum	4
Pons	2
Cerebral peduncle	1

10. Heimann,
Arch. f. Ohrenk., 67, 1,
1905-06.

570 cases of brain abscess of otitic origin, 80% due to chronic otitis media, 20% to acute otitis media.

11. Sanford,
Am. J. Dis. Child 35: 256, 1928.

The general opinion is that abscess of the brain rarely occurs in young infants. Holt (cited by Sanford) collected 27 cases of brain abscess which occurred in the first ten years of life; 13 of these occurred during the first twelve months.

In a small series of cases, the etiology was distributed as follows:

Unknown	33%
Otitis	31
Trauma	16
Infection	10
Spina bifida	5
Birth injury	5

Prognosis: Except for one questionable case, the mortality was 100%. "Abscess of the brain must be considered

when an infant has bizarre cerebral symptoms (100% convulsions) accompanied by a spinal fluid showing an increased number of cells and a culture of pyogenic organisms."

12. Adson,
J.A.M.A. 75: 532, 1920.

Heimann (cited by Adson), 535 cases of brain abscess of otitic origin found only 3 in children under 5 years of age. Adson reports 26 cases of brain abscess, 9 were operated upon, 5 recovered and 4 died shortly after the operation.

Etiology in 25 cases:

Frontal sinusitis	6
Chronic otitis media with exacerbation	5
Chronic empyema	5
Injury to the skull	4
Frontal sinusitis with osteomyelitis	2
Chronic empyema with "septicopyemia"	1
Old pulmonary tuberculosis	1
Bronchiectasis	1

13. Woltmann, H. W.
J.A.M.A. 100: 720-722,
(Mar. 11,) '33.

The optimal time for drainage is seldom as early as 2 weeks and often as late as 6 weeks after the period of invasion. "The risk of performing spinal puncture in cases of brain abscess has probably been overrated, and thus physicians have been deprived of information that might be helpful."

He reports 36 cases of verified brain abscess in which lumbar puncture was done.

"After invasion of the brain has taken place and the formation of an abscess gets under way, the number of neutrophils in the spinal fluid becomes absolutely and relatively reduced.

"A small number of lymphocytes would seem, on the whole, to indicate better encapsulation, greater resistance and a

smoother convalescence after operation."

14. Lillie,
Surg., Gyn. and Obst. 47:
405-406, (Sept.) '28.

"Stationary choked discs in cases of brain abscess observed over a short period of time indicate encapsulation."

15. Knapp, E.
Ztschr, f. d. ges. Neurol. u.
Psychiat. 139: 44-52, '32.

Capsule formation cannot always be correlated with duration of the disease. Even after one year, there may be little evidence of capsule formation. In 19 brain abscesses, there was no evidence of glial participation in 18. In one, apparently a case of long standing (probably $4\frac{1}{2}$ years), there was evidence of slight glial participation. He cites a case (reported in Munch. Med. Voschr. H., 4: 109, 1917) of a 38 year old brain abscess in which there was evidence of gliosis.

16. Worms, G.
ASPIRATION THERAPY
Bull. et mem. Soc. nat. de.
chir. 59: 642-651 (May 6), '53.

He reports 5 cases treated by aspiration, 2 died. One had a foreign body removed beside aspiration therapy.

17. Cahill, H. P.
MODERN TREATMENT
J.A.M.A. 102: 275-276.

In the discussion of this paper, Dr. Adson describes a method of treatment for brain abscess. A small decompression is made over the abscess, fixing the meninges to the cortex with cutgut sutures and electrically coagulating the margins. The abscess is partially drained with a brain cannula, after which the capsule is incised along the cannula. The capsule is held with a bivalve speculum with lateral flanges. The re-

maining pus is evacuated and the cavity is explored with an illuminated retractor, necrotic tags are removed and lateral pockets are thoroughly cleansed. Then two rubber tube drains and two strips of iodoform gauze are inserted, the gauze is packed loosely about tubes and into pockets to prevent sealing of recesses which might cause recurrence. The gauze packs prevent falling of the capsule and retraction of the brain from the skull. The gauze drains are removed slowly over a period of a week, allowing the capsule to contract and form a sinus around the tubes. The tubes are likewise shortened during the second and third weeks, thus permitting granulation and obliteration to take place from the dependent regions first. "Sterile abscesses might be effectively drained by repeated aspiration but even then recurrence can take place. Surgical recovery and prevention of recurrence are achieved by waiting for encapsulation and the development of immunity with thorough, adequate and continuous drainage."

18. Armitage, F. L.
 J. Trop. Med. & Hyg. 12: 69,
 1919.

He found reports of 48 cases of brain abscess associated with amebic dysentery. (Cited in Textbook of Medicine, Cecil, 2d Edition).

Alex Blumstein.

III. SOUND MOVIES

Title:

Fundamentals of Acoustics -

By the University of Chicago --
 One reel.

IV. POEM

ON CLINICS

Far down the narrow halls I look and see
 Long rows of chairs set firm against the
 wall,
 And people sitting, nervously alert,
 Guarding, with patient care, a tender wound,
 Or resting from the burden of a crutch;
 Keenly they watch each patient come and go,
 And by comparison, gain some reward;
 Seeking, perhaps, a sympathetic ear
 In which to voice that pent-up hope or
 doubt.
 The nurse, with kind but noncommitting
 smile,
 Trained to endure, brings recompense to
 some;
 The very air is heavy with suspense;
 Seeking a chair to hush my trembling knees,
 I try to look indifferent and calm.

Slowly, the owner of a name now called,
 Will follow in, beyond the closing door;
 With mingled fear and courage, he draws near
 And nearer to the knowledge of his fate;
 The waiting-booth seems vault-like and
 severe;
 In awkward haste, he drapes his winding-
 sheet,
 And, finding little comfort in the bench,
 Soon wonders if his turn will ever come.
 Then, as the doctor's reassuring words
 Restore his courage and renew his nerve,
 He joins that ever-growing, anxious throng,
 Who walk in shadows, daring still to hope;
 Facing a conflict, earning many scars:
 Brave soldiers of a clinic battle-ground.

 One of our patients.