Puerperal subdural empyema

Sir, Intracranial complications during pregnancy or the puerperium may manifest in the form of seizures, neurological or endocrine deficits, or deterioration in sensorium. Subdural empyema complicating an otherwise uneventful pregnancy or puerperium, to the best of our knowledge, has not been reported earlier.

Case report
A 20-year-old woman delivered a normal full-term baby in hospital in March 1994. She was normotensive and gave no history of taking oral contraceptives. On the fifth post-partum day, she complained of increasing headache followed by generalised tonic-clonic seizures. Seizures were controlled by intravenous diazepam. Clinically, she was drowsy, febrile and had paresis of her left lower limb with Babinski sign. Fundus was normal. There was no evidence of chronic middle ear disease or sinusitis. Computed tomography (CT) of the brain showed falcial subdural empyema (figure). Antibiotic therapy (penicillin, chloromycetin, metronidazole) was started and the subdural empyema was evacuated by a burr hole. About 30 ml of thick creamy pus was evacuated. There was rapid resolution in her symptoms and she was discharged after six weeks of antibiotic therapy. Pus and blood cultures were sterile. She was asymptomatic at the time of last review in May 95.

Subdural empyema is an uncommon intracranial supplicative lesion, known for its high mortality and morbidity. It constitutes 13–20% of all intracranial suppurations. In a study from Chandigarh, it was seen to account for 10% of all intracranial suppurations. In the Western literature, the common predisposing factors quoted are parasanal sinusitis and meningitis. Chronic middle ear disease is a major aetiological factor from India. Other aetiological factors may be trauma and subdural effusion. We could not find any report of pregnancy or puerperium being associated with subdural empyema. In view of the absence of other known aetiological factors, one can only surmise that the parturient uterus acted as a port of entry for infection in this case.

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Discussion CPR with patients and relatives

Sir, We read with great interest the recent article on the difficult subject of discussing cardiopulmonary resuscitation (CPR) with patients and relatives. Dr Stewart gives excellent advice on when and not to involve patients and relatives in discussions on do-not-resuscitate orders. We concur with his advice. However, he does mention, in reference to a study we conducted, that confusion exists amongst patients, relatives, doctors and investigators. We questioned 100 patients and their relatives about different aspects of CPR in the department of medicine for the elderly prior to a revolution of a CPR policy. All patients were told what CPR entailed and also about the futility of CPR in certain cases, e.g., carcinomatosis. Interestingly, of 13 patients who had ‘Do not resuscitate’ in their case notes, eight of these wanted to undergo CPR. This led us to contact the defence unions quoting a particular case of a very elderly gentleman with metastatic bronchial carcinoma who was insistent on having CPR despite advice given to him by two doctors. Both defence unions suggested that he should not be denied CPR if he was consistent, although they subsequently refused this advice. Clearly, instituting resuscitation in a futile situation like this is totally inappropriate and therefore we agree it would be detrimental to discuss this with the patient unless he/she insists on discussion. Since our study we have realised the importance of adhering to a CPR policy. Our policy now includes advice about discussing these issues with patients and relatives. CPR status is considered on admission and each week all patients’ CPR status is discussed in a case conference with nurses, junior doctors and paramedical staff, as well as being considered on all the consultants ward rounds. We discuss CPR status with patients in appropriate circumstances. However, doctors (even senior ones) often lack the communication skills required for this and certainly these skills are not imparted as part of undergraduate or postgraduate training. It is sometimes difficult even to bring up the subject of resuscitation with a patient but including details of CPR policy in written information given to patients may be helpful in opening the conversation, eg., ‘I wonder whether you have read this part of your hospital booklet Mrs Brown which talks about resuscitation? What do you think about that? Are there any questions you want to ask me about resuscitation?’ We find that this is often a good way to open the conversation on resuscitation with patients. Written information, however, is certainly not a substitute for the doctor discussing these important issues with patients in appropriate circumstances. In order for the doctor to perform these duties in a caring compassionate manner it is essential that he/she receives adequate training in these communication skills.

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Polymyalgia rheumatica, temporal arteritis and malignancy

Sir, We read with great interest the recent article on polymyalgia rheumatica, temporal arteritis and malignancy. We wish to report a similar case in a 61-year-old woman who presented to her general practitioner with a six-week history of proximal muscle pain and stiffness. Her erythrocyte sedimentation rate (ESR) was 138 mm/h and a diagnosis of polymyalgia rheumatica (PMR) was made. Her symptoms responded dramatically to prednisolone 20 mg/day but her ESR remained elevated at between 71 and 79 mm/h. The patient was referred for further investigation and was found to have an IgA kappa paraproteinaemia of 28.4 g/l. Urinary Bence Jones proteins were absent. Her full blood count, renal function and serum calcium were normal. A bone marrow biopsy revealed an infiltrate of morphologically abnormal plasma cells accounting for 30% of all nucleated cells, consistent with a diagnosis of multiple myeloma. A skeletal survey showed a wedge fracture of one of the mid-thoracic vertebral bodies.

In 1987, Kalra and Delameare described five patients presenting with PMR-like symptoms who were found to have a monoclonal gammopathy and suggested that PMR could

Puerperal intracranial complications

- Cortical venous thrombosis
- Subarachnoid haemorrhage
- Increase in the size of tumours such as meningioma
- Post-partum pituitary infarction

Figure CT showing falcal subdural empyema