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 falcine subdural empyema (figure). Antibiotic therapy (penicillin, chloramphenicol, 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 suppurtive lesion, known for its high mortality and morbidity. It constitutes 13–20% of all intracranial suppurations.1-7 In a study from Chandigarh,8 it was seen to account for 10% of all intracranial suppurations. In the Western literature, the common predisposing factors quoted are para nasal sinusitis5 and meningitis.6 Chronic middle ear disease is a major aetiological factor from India.1 Other aetiological factors may be trauma4 and subdural effusion.7 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.

Discussion of 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.1,5 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.2 We questioned 100 patients and their relatives about different aspects of CPR in the department of medicine for the elderly prior to the revolution of a CPR policy. All patients were told what CPR entailed and also about the futility of CPR in certain cases, eg, carcinoma. 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 bronchiol carcinoma who was insistant on having CPR despite advice given to him by two doctors.3,4 Controversies in the management of subdural empyema. A study of 41 cases.5 J Neurosurg (Wien) 1990; 182: 25–32. 6 Redondo A. Suppurative intracranial complications of upper respiratory tract infections. Pediatr Infect Dis J 1987; 6: 224–7. 7 Mathur K, Bhatia R, Banerji AK, Tandon PN. Subdural empyema in children. Indian Pediatr 1984; 21: 561–7.

We would like to comment on 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.

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Puerperal intracranial complications

- cortical venous thrombosis
- subarachnoid haemorrhage
- increase in the size of tumours such as meningioma
- post-partum pituitary infarction

Figure CT showing falcine subdural empyema


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.

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