Letter to Editor


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Fulminant subdural empyema-an unusual complication of pyogenic meningitis

Sir,

An otherwise normal 56-year-old diabetic patient presented with a one-day history of multiple generalized tonic-clonic seizures followed by altered sensorium. There was no history of fever. There was no history of trauma or any focus of infection. There was no focal neurological deficit or signs of meningitis.

Hematological investigation revealed leucocytosis with a total white blood cell count of 16,600/cu.mm and an ESR of 45 mm. Blood sugar was 351 mg%. Computed tomography (CT) scan of the brain revealed no abnormality (Figure 1). The lumbar CSF analysis revealed 1350 cells/mm with 96% neutrophils and 4% lymphocytes. Blood and CSF cultures did not reveal any growth. A diagnosis of pyogenic meningitis with diabetes was considered and the patient was placed on broad-spectrum antibiotics. Two days after admission to the hospital she developed recurrent attacks of seizures, lapsed into altered sensorium and developed a left pupillary dilatation. Repeat CT scan revealed a left fronto-parietal hypodense, extracerebral fluid collection with severe brain edema causing midline shift and obliteration of the basal cistern (Figure 2). An emergency left frontal burr hole was done and thick pus was evacuated. Gram’s stain revealed pus cells and gram-

Figure 1: Plain and contrast CT scan of the brain done on 07/11/2003 shows no significant abnormality
Figure 2: Plain and contrast CT scan of the brain done on 09/11/2003 shows a left fronto-parietal hypodense, extracerebral fluid collection with severe brain edema causing midline shift and obliteration of the basal cistern.

Sir,

Periodic lateralized epileptiform discharges (PLEDs) are a well-defined electroencephalographic entity known for the past four decades. PLEDs have been associated with both partial and generalized seizures, and typically with status epilepticus (SE). PLEDs were found in only 0.5% of 8002 pediatric electroencephalographic (EEG) studies. PLEDs have been described in association with a variety of conditions including cerebrovascular accidents, viral encephalitis, subdural hematoma, metabolic abnormalities, mitochondrial encephalomyopathy, diffuse neurocysticercosis, neurosyphilis and acquired immunodeficiency syndrome. Approximately two-thirds of pediatric cases are related to central nervous system infections.

A ten-year-old child, the youngest of nine siblings, was brought with a five-hour history of repeated right focal motor seizures. He had twitching of tongue and right hand associated with tonic deviation of head to the right side. Initial episodes were secondarily generalized, but after admission, he continued to have right focal motor seizures without loss of consciousness. A clinical diagnosis of status epilepticus was made. He was treated with intravenous lorazepam and phenytoin loading dose with which his seizures were controlled.

Contrast brain CT scan (Figure 1) showed features suggestive of a solitary cysticercus granuloma (SCG) in the left medial frontal lobe. Electroencephalogram (EEG) done the following day (Figure 2) showed persistent periodic bursts of biphasic sharp-wave discharges up to 500 mv in amplitude, periodic lateralized epileptiform discharges (PLEDs) over the left hemisphere with predominance to the central and parietal regions, occurring at a frequency of one per second. Serum anticysticercal antibody was positive.

EEG repeated after ten days had normalized. The child has been seizure-free during 15 months of follow-up and a repeat CT scan seven months after the initial presentation showed...