Letters to Editor

get relax after osmotic diuretics and mannitol, wound should be closed after attaining hemostasis (without replacing the bone flap) and immediate CT scan should be undertaken. If CT scan is not available, alternate option is exploratory burr holes, which can be made contralaterally (first over the fracture site) in the temporal, frontal and parietal locations (in that order).\(^1,2\) As shown by our case, posterior fossa burr holes are also indicated if there is an overlying fracture or other burr holes reveal no hematoma.

To the best of our knowledge, intraoperative development of PFEDH is not reported in English literature.

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References


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Supratentorial intracerebral haemorrhage following posterior fossa operation

Sir,

A 63-year-old woman had a history of headache and progressive ataxia over 1 year. Neurological examination showed a horizontal nystagmus, a slight gait ataxia, right dysmetri and bilaterally papiledema. CT scan also revealed a calcified meningioma of 6x5x5.5 cm in size in the right posterior fossa with moderate hydrocephalus [Figure 1]. Preoperative right carotid and right vertebral artery angiographic scan has been done. The patient underwent suboccipital craniectomy in sitting position and ventricular drainage have been performed to prevent air embolism. So intraoperative course was uneventful and tumor removed totally [Figure 2]. In early postoperative neurological examination was normal but after six hours she became somnolent and developed a hemiplegia on the left site.

A new CT scan revealed a hyperdense lesion of 2x1, 5x4 cm in size in the right fronto-parietal region [Figure 3]. The patient was treated conservatively and the patient’s neurologic state improved in five days. CT scan revealed a hypodense lesion in the right fronto-parietal region in subsequent second month [Figure 4].
The literature on supratentorial intracerebral hemorrhage following posterior fossa surgery is rare. Heiness et al reported 5 supratentorial hemorrhages after posterior fossa operation in 825 patients firstly. The patients had neither coagulopathy nor predisposing factors,[1,2] Harder et al presented 3 supratentorial intracerebral hemorrhage in 187 posterior fossa surgery.[3] The mechanism of intracerebral hemorrhage after posterior fossa surgery is unclear. Harder et al have suggested that the surgery in sitting position may decrease intracerebral arterial blood flow, causing cerebral ischemia. As soon as the patient puts back in normal position after surgery hyperperfusion leads to intracerebral hematoma in ischemic brain tissue.[4]

Changes in intracranial dynamics in the sitting position are known to produce subdural hematomas by disruption of cortical bridging veins. By the same mechanism, subcortical veins might be torn and cause intracerebral bleeding.[2] Cartier-Giroux J, suggested that the removing of tumor may have irritative effects on vasomotor area in medulla, causes sudden increase in arterial pressure consequently massive basal ganglia bled. Otherwise, it may be related with rapid release of longstanding elevated intracerebral pressure by posterior fossa surgery in the sitting position with loss of CSF with consecutive tearing on the ependymal ventricular walls.[4] Impaired blood coagulation after meningioma surgery is well known.[2,3]

Our patient underwent an operation in sitting position with ventricular drainage for relief of increased intracranial pressure. In both preoperative and postoperative period her coagulation parameters were normal. Mean arterial pressure values coursed at normal ranges throughout the operation and pre and postoperative periods also. In our case the remote hematoma has occurred in right deep parietal and frontal region it may be derived from tearing of subependymal or basal ganglia perforating veins. The neurological deterioration after 6 hours surgery supports this probability.

Figure 4: Second month of the postoperation CT scan demonstrates right fronto-parietal hypodense lesion (infarct).

Discussion

Supratentorial intracerebral hemorrhage following posterior fossa surgery is scanty and this pathology should be suspected in patients who develop new neurological deficit and detailed neurological examination in the early postoperative period is the best way to identify supratentorial pathology by CT scanning and may be vital.

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Post-traumatic bilateral abducens nerve palsy

Sir,

We like to report a relatively rare case of bilateral sixth nerve palsy following trauma. A 35-year-old-gentleman was admitted with a history of road traffic accident 2 hours ago. Neurologically, his glasgow coma scale (GCS) was 15/15. He had revealed bilateral 6th nerve palsy without any other deficits.

He was evaluated with CT scan brain (plain), which revealed pneumocephalus in the prepontine cistern and other multiple fractures [Figures 1 and 2]. He was managed conservatively and also started on oral steroids in view of the nerve palsy. Repeat CT scan brain revealed resolving pneumocephalus. He was discharged on antibiotics and oral steroids for a period of 3 weeks. On follow up, his sixth nerve palsy was gradually improving.

Bilateral abducens nerve palsy following trivial trauma is a relatively rare occurrence. Berlit et al evaluated 165 patients suffering from abducens nerve palsy as the main presenting symptom.[1] A vascular origin (29.7%), inflammatory diseases (19.4%) and tumours (10.9%) were the most common causes while traumatic abducens paresis (3.1%) was rare. Posttraumatic