Benign intracranial hypertension syndrome following a hymenoptera sting

Sir,

A 42-year-old lady with no past history of any other medical illness was transferred to our unit with complaints of fever, severe headache and toxemia following a wasp sting over the right eyelid 5 days prior to the transfer. The sting was associated with a large amount of local swelling and cervical adenopathy. She had received two short courses of antibiotics prior to her transfer; and routine investigations, including a complete blood count, biochemistry and urine done previously and repeated by us, were unremarkable. Fundoscopy showed evidence of early papilledema. A CT scan and an MRI of the brain were normal as was an MR venography. In view of the fact that the patient’s fever persisted and she had mild neck stiffness, a CSF study was done and the opening pressure was markedly raised at 300 mm of CSF; however, estimations of CSF proteins, sugar and cell counts were normal. No specific treatment was instituted and the patient was given small doses of oral glycerol with partial relief of her headache. The fever settled spontaneously in the following few days and the patient was discharged. The patient returned for a follow-up examination after a month, when the CSF pressure was rechecked and found to be significantly diminished at 150 mm of CSF. The patient had remained well and asymptomatic.

Hymenoptera stings are associated with a variety of neurological and non-neurological symptoms. In most instances, the local reactions are mild and last longer. However, the systemic reactions may be immediate and life threatening (anaphylaxis), warranting emergency treatment. Both these reactions are secondary to an inflammation due to the wasp venom. Neurological complications described have included a parkinsonian syndrome,\textsuperscript{1} optic neuropathy,\textsuperscript{2} an encephalopathy, a myeloradiculopathy\textsuperscript{3} and focal neurological deficits.\textsuperscript{4} There have been no prior reports of a benign intracranial hypertension syndrome following Hymenoptera venom intoxication. Our patient did not have any
wasp or insect stings in the past (which would have hypothetically favored a hypersensitivity reaction). In this case, the proximity of the sting (on the eyelid) to the CNS may have been a factor in causing the elevated CSF pressures as a result of intracranial inflammation due to the potentially neurotoxic wasp venom. No other cause for the elevated CSF pressures could be found (our patient was not on any oral contraceptive pills) and resolution of the intracranial hypertension occurred spontaneously and within the expected time frame, suggesting a temporal correlation between the cause (wasp sting) and the event (raised intracranial pressure). Insect stings are generally regarded as benign, but it is worth remembering that in some cases, as in this one, venom intoxication may be responsible for some unusual clinical manifestations.

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