

INTRACRANIAL COMPLICATIONS WITH RHINOGEN ETIOLOGY - A CASE REPORT

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In spite of the considerable advancement in diagnosis and treatment of phlogistic diseases of the ears, the nose and the throat, they take a hard course, have serious forecast and much too high lethality. Their pathogenesis is a result from anatomotopographical peculiarities of the nose and paranasal cavities. Some authors mention the particular role of the upper wall of the nasal cavity which is in the immediate vicinity of the crane cavity and the existing anomalies in the development of the ethmoidal labyrinth. This makes us sure that the contact way of infection penetration is more often than the haematogen one.

The patient is S.M.D. a 10 year-old boy, case report 9648/13 Aug. 1991, PCRIT. On Aug. 11, 1991 the patient presented into the ENT ward of the Razgrad General Hospital with meningoencephalitis diagnosis, in a very bad general condition, sociable, agitated and there were some data of meningoradicular irritation. C.S.F.:cells 144 leukocytes, albumin 0.78%, Pandy negative; ESR 64 mm, leukocytes 27200, eye bottoms - without peculiarities. On Aug. 12 the patient is stuporous, having very strong frontal and occipital headache; temperature up to 39 °C ; C.S.F. cells were 560 leukocytes, albumin 1.44%, eye bottoms - without change. Four-five days before admission to the hospital the child having a frontal headache and painful radix nasi, fleeting swelling on the right eyelids and next a durable one on the left eyelids. In spite of the treatment the headache intensified, nausea and vomiting appeared and breathing through the nose became impossible. Parents did not report past diseases, neither nasal trauma. On Aug. 12 the examination revealed a swelling of nasus externus, unchanged skin colour, livid swelling of the both eyelids, ptosis of the upper left eyelid, paralysis of the nervus abducens, a swelling of the left cheek, a bilateral swelling behind angulus mandibulae, trismus. Both nasal tracts in vestibulum nasi were obstructed by symmetrical swellings, fluctuating when being palpated. At the incision of the swellings a great quantity of thick pus was evacuated. On Aug. 13 the patient was brought to PCRIT - Varna for complex intensive treatment with a diagnosis: **ABCESSUS SEPTI NASI. MENINGOENCEPHALITIS PHINOGENICA. OBS. THROMBOPHLEBITIS SINUS CAVERNOSUS. SEPSIS.** We prescribed a powerful antibiotic, dehydrating, disintoxicating, general

strengthening, immune and anticoagulant treatment. On Aug. 15 the agent *Staphylococcus aureus* was isolated and in accordance, antibiotic treatment was held, antistaphylococcic gammaglobulin was injected and staphoplasma was transfused. In the next days vomiting of haematin matters appeared, headache grew stronger and on Aug. 19 ophthalmoplegia totalis of the right eye appeared with a preceding tic of the eyelids and a pale temporal papilla. A picture of hard meningoencephalitis and sepsis developed, paraplegia of limbs and urine incontinence urine. On Aug. 24 the first symptoms of backward development of the disease appeared. On Aug. 20 the computer tomography showed a small hypodense zone on the right in the area of the basal nuclei; on Aug. 27 the aforescribed lesions had undergone a backward development. Some new hypodense lesions were seen around the third ventricle basally. C.S.F. Aug. 20: Pandy (\bar{n}), chlorides 99.5, sugar 2.4, albumin 2.2, cells 9900 - leukocytes, xanthochromic; on Aug. 30 C.S.F. is colourless, Pandy , albumin 0.48%, sugar 2.65, chlorides 118, cells 224 - mostly mononucleous. On the next computer tomography liquid in the maxillar and ethmoidal sinusi was found which we considered as secondary and not needing an operative treatment. In the reconvalescent period the clinical picture was dominated by the intoxication syndrome with leukocytosis, anaemia, accelerated ESR. As a consequence of the perichondritis of the septum cartilage the nose changed its shape. Ophthalmoplegia syndrome began backward development. The child quickly recovered the activity deficiency and the mental disturbances. After two months treatment in the Clinic the child went home as clinically healthy and is under observation now.

The atypical clinical picture made it difficult to consider the primary complication. The way the primary clinic developed and the lack of stagnation effects in the orbit gave us a reason to suggest that the purulent process penetrated into the endocranium mostly along the contact way directly through the lamina cribrosa. However, differential- diagnostically, the lack of such changes and the way the clinic developed later with encephalitis symptoms, the fluctuating and migrating clinical picture, had made us consider THROMBOSIS SINUS SAGITALIS SUPERIOR as a primary complication. In spite of the great diagnostic possibilities of modern medical apparatus, the clinical survey and observation are basic diagnostic and prognostic methods in the disease course.