

Answers on p 377.

Swelling in the caesarean section scar

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Submitted 8 June 1999
Accepted 12 July 1999

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A 38 year old women, para 3+1, presented with a two month history of painful swelling in her caesarean section scar. She had two caesarean sections seven and 10 years earlier. She had a long history of irregular menstrual periods.

On examination there was a tender, firm 2 × 2 cm swelling in the right side of the phannensteil incision scar. There was no cough impulse.

Questions

- (1) What is the differential diagnosis?
- (2) What investigations should you consider?
- (3) How would you treat this patient?

An unusual case of chorea gravidarum

Answers on p 378.

A Qasim

A 24 year old right handed Pakistani woman who was eight weeks' pregnant presented with a two day history of involuntary movements of her left arm, hand, and foot. There was no significant past medical history or family history, and she was taking no regular medication. On examination there were choreiform movements of the left upper limb and left foot. Her speech was normal and there was no other neurological abnormality. She was afebrile, and examination of the cardiovascular, respiratory, and abdominal systems was unremarkable. Fundoscopy and slit lamp examination of the eyes was normal. Full blood count, urea and electrolytes, liver function tests, and thyroid function tests were normal. She had a polyclonal rise in IgG, with no evidence of autoantibodies. C reactive protein was <6 mg/l and the antistreptolysin O titre 320. Electrocardiography and echocardiography showed no abnormalities. Obstetric ultrasound was performed which showed a viable fetus with estimated gestational age of 10 weeks. Magnetic resonance imaging (MRI) of the brain was normal. She was treated with haloperidol 1 mg three times daily and her chorea improved markedly over the next three days.

On day 8 she suffered a primary focal seizure with violent movements of the right arm leading to a secondary generalised seizure. Emergency computed tomography of the brain with and without contrast showed no abnormality. Cerebrospinal fluid obtained by lumbar puncture was sterile with normal cell counts. An electroencephalogram was asymmetrical with generalised excess of left sided theta and delta waves unaffected by photic stimulation. In the 24 hours after the seizure she developed expressive dysphasia, right sided hemiplegia, and worsening left sided chorea. MRI of the brain was performed on day 10 (fig 1). She was anticoagulated with intravenous unfractionated heparin, and within six hours there was an increase in right sided power to grade 4 out of 5 and improvement of her dysphasia and

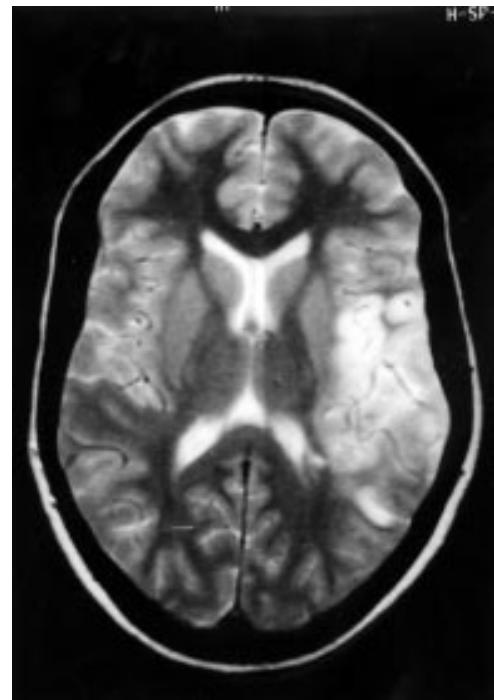


Figure 1 Axial image from MRI on day 10 after admission.

chorea. After bleeding from her vagina on day 27 miscarriage was diagnosed on obstetric ultrasound. She was discharged after 35 inpatient days: she had mildly reduced right sided power (grade 4 out of 5) and mild dysphasia. Life long treatment with warfarin is planned and she has been advised against future pregnancies.

Questions

- (1) Give a differential diagnosis of chorea in pregnancy
- (2) Describe the abnormalities in the MRI image (fig 1)
- (3) What underlying causes should be sought in this patient?

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Submitted 1 June 1999
Accepted 13 August 1999

Nausea and vomiting, a cause for concern?

Aftab Ala, Natasha Arnold, Cho Cho Khin, Niall van Someren

Answers on p 379.

A 72 year old man with manic depression, who had recently started lithium treatment, presented to casualty with a two day history of severe nausea and vomiting. His serum urea and electrolytes were normal (sodium 139 mmol/l, potassium 4.1 mmol/l, creatinine 94 mmol/l, and urea 5 mmol/l) and he was discharged from the accident and emergency department with a presumptive diagnosis of gastroenteritis.

He represented 12 hours later with persistent vomiting and oliguric prerenal failure initially thought to be secondary to lithium toxicity. There was only minimal tenderness in the epigastrium but no signs of peritonism or abdominal masses; his pulse was 90 beats/min and blood pressure 105/50 mm Hg without a visible jugular venous pressure. His blood urea was now 28 mmol/l, sodium 141 mmol/l, potassium 4.3 mmol/l, and creatinine 310 mmol/l, with normal full blood count, blood gases, creatinine kinase, amylase, urine microscopy, a subtherapeutic lithium concentration



Figure 2 Lateral chest radiograph.

0.35 mmol/l (normal range 0.4–0.8 mmol/l), and an electrocardiograph showed sinus tachycardia only. His central venous pressure was low (–2 mm Hg) and he was resuscitated with fluids. Chest radiography was performed (figs 1 and 2) and a nasogastric tube was inserted but with some difficulty, draining only 100 ml of gastric juice. Twelve hours later his symptoms still had not improved. His renal function was unchanged and his vomitus had now become blood stained.

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Submitted 15 October 1998
Accepted 5 July 1999



Figure 1 Erect posteroanterior chest radiograph. The fluid level (arrowed) represents a paraoesophageal hernia with a large gastric volvulus.

Questions

- (1) What do the chest radiographs show?
- (2) What single diagnostic investigation is required?