Unusual clinical presentations of intracranial suppurative complication of sinusitis make it difficult to be diagnosed and make it a challenging task. Even in present time this pathology is known to produce significant morbidity and mortality. A short review of the literature on ICS has been done with our experience of two cases who had varying clinical presentations and despite of their management with limited available resources, both the cases recovered fully with limited morbidity.

The first case, a 12 years old boy had no clinical evidence of sinusitis but had high fever, signs of increased intracranial pressure, orbital cellulites and abscesses on left upper eye lid and on same side of forehead. The CT scan revealed Fronto- Maxillary sinusitis, periorbital cellulites, lid and forehead abscesses along with oedema in brain for which an external Fronto-Ethmoido-Maxillary antrostomy [Lynch-Howarth operation] was done along with drainage of extra cranial abscesses in the eyelid and forehead.

The second case, a 21 years old female, known to have nasal allergies had a high fever, right eye congested and proptosed and had signs of increased ICP. The CT and MRI revealed that she had a subdural empyema, Frontal sinusitis and a periorbital Cellulites. The subdural empyma was drained by a neuro- surgeon and the sinus abscesses were drained [Lynch Howarth operation] by an Otolaryngologist, at the same time. Both the patients recovered in 4 to 6 week.

In conclusion, the diagnosis of ICS requires a high index of suspicion and early radiographic imaging [CT/MRI] of the head and paranasal sinuses. An aggressive medical therapy is indicated and it may require drainage of the sinus abscess and the intra cranial abscess, at the same time.
because of its high vascularity, rich network of diploic veins and frequently associated anterior ethmoid sinusitis. The suppurative intracranial infections like meningitis, epideral abscess, subdural empyema, thrombosis of cavernous sinus and other dural sinuses and encephalitis are uncommon but serious sequelae of paranasal sinusitis and a high index of suspicion is necessary to identify these serious complications. We present a patient with subdural empyema in whom the diagnosis was delayed and it deteriorated rapidly producing a true neurosurgical emergency, similar to a finding in a series[3] stating that a subdural empyema requires a prompt diagnosis and management. Location of an intracranial infection strongly influences the clinical presentation and the disease course. Extra cranial complications, especially orbital infections commonly coexist with ICS. These concurrent orbital and forehead complications often have a predilection for epidural abscesses and their presence increase the likelihood of earlier diagnosis of ICS.

Most important investigation is a CT scan or a MRI. An ICS can be prevented by an early diagnosis and treatment of sinusitis by a medical treatment and, if required, by a surgical intervention like the drainage of the sinuses by antrum lavage, a functional endoscopic sinus surgery (FESS) or by an external approach antrostomy. Once diagnosed, the management for ICS requires an aggressive treatment offered by a physician [including culture directed intravenous antibiotics which penetrate cerebrospinal fluid] and the abscesses [of sinus and intra cranial collection] need surgical drainage by an otolaryngologist along with a neurosurgeon, at the same time.

Methods

To review the literature on ICS [patterns of presentation, imaging, microbiology, FESS therapy, disease course and it is sequelae] the references were taken from different series of studies to compare with our experience of two cases.

Case Reports

First Case

A 12 years old boy presented with cough and cold, left sided headache with same side swollen eye, high fever, vomiting and an abnormal behavior for two days. The past history and clinical examination revealed nothing significant for E.N.T. pathology hence a provisional diagnosis of left orbital cellulitides with menigitis was made and a treatment started by a physician but the condition deteriorated and also an abscess developed on his forehead [figure; 2a]. A Lumber puncture was done where the CSF was straw colored, cloudy and had normal pressure with glucose120mg, proteins -56 mg, WBC 1536 /c.m.m. [predominantly neutrophils] and RBC 186 /c.m.m. The Gram stain of the CSF revealed bacteria and the culture showed coagulates negatively Staphylococci species [sensitivity not done]. These findings suggested a bacterial menigitis and a radiology investigation was required hence advised a CT scan and MRI but patient could not afford it in private set up so an X-ray of P.N.S. was advised which revealed a fluid level in the right Maxillary sinus and the mucopus was drained by an antrum lavage. Still his condition worsened, developed generalized seizures and somehow a CT scan [figure; 2b,c.] was managed to be done which showed an opacity in left maxillary and ethmoidal sinuses, left periorbit-
Cranial Complication of Sinusitis

Frontal sinuses were drained [figure; 5a.] through an external route [Lynch Howarth’s operation] by an otolaryngologist. The Gram’s stain [of the pus from sinuses] revealed Gram-positive bacteria but no growth was found on culture. Post operatively bilateral Lateral rectus palsy [figure; 6a.] was noticed but it fully recovered in next 6 weeks [figure; 6b]. Results- Both the cases recovered fully in spite of non FESS [ external sinostomy] management, the child in 2 weeks and the adult who had a morbidity of bilateral Lateral rectus palsy, recovered in 6 weeks. Both the patients were discharged with prescription of broad spectrum antibiotics for 4 weeks and anti-epileptics [Phenytoin], six months for the child and one year for the adult case. Figures- 4,5

Figure 4: A- Maxillary and Frontal sinus External Sinostomy; B - Subdural empyma, drained through bur holes.

Figure 5: A- Bilateral lateral rectus palsy; B-Patient fully recovered in six weeks.

Discussion

This serious pathology can be diagnosed early and managed efficiently with help of advanced radiology [CT scan and MRI] and surgical techniques [FESS and neurosurgery] and in absence of these facilities it becomes a challenging task. Guyana, a former British colony with a population of 751,000, is one of the poorest countries of the Americas and has one of the lowest health status indicators of its region. There are only a handful of Otolaryngology specialists. Georgetown Public Hospital Corporation (GPHC) serves as the national tertiary care teaching hospital where the majorities of complicated otolaryngology cases are seen and are faced daily with challenges[4]. There is a lack of modern surgical equipments and skill [for FESS], consumables in pathology [microbiology and histopathology] and an affordable advanced radiology [CT/MR]. It is within this context that we describe the diagnosis and management of two cases who had a rare and serious complication of sinusitis.

J.A. Griller, et al[5] reviewed different series of studies on suppurative ICS and found out that most of the patients [including ours] had no history of prior sinus surgery and usually the symptoms are nonspecific like fever, headache, facial swelling, the ocular findings like proptosis and periorbital cellulites and the common neurologic symptom was mental status change [disorientation]. Similarly T.K. Nicoli, et al[6] in their study, had the patients who presented with signs of raised intracranial pressure rather than signs of sinusitis and the most common presenting complaint was headache (100%) followed by fever (83%), nasal congestion (50%), vomiting (50%) and forehead lump (34%). All patients were managed surgically [neurosurgical intervention and evacuation of the abscess, as early as possible] and most (83%) patients recovered to premorbid state without neurological sequelae. In another study[7], neurological signs were the most frequent symptoms but contrary to our cases the rhinological signs were essentially purulent rhinorrhea and nasal obstruction. The duration of symptoms [pain and swelling on face] was shorter [3 days] contrary to 12 days, in series[8]. In the adult case the ICS was secondary to chronic sinusitis as found in the series[8] and in the child case it was secondary to acute sinusitis as seen in a pediatric series[9]. The hospital stay was 28 days for the adult and 14 days in the child case similar to stay of 15 - 30 days seen in few series[10,9]. Clinical presentation and the disease course depend on the site of intracranial infection[10]. The adult case had a subdural empyma, a common intra cranial complication of sinusitis as mentioned in the series[11,12,13] and in the child case it was the epidural abscess, commonly seen as in the series[8,14,15]. In a study[16] of 23 patients of ICS, as per CT scan there were subdural empymas (11 cases), extradural empymas (7 cases) and brain abscesses (5 cases). Associated cerebral thrombophlebitis was noted in 4 cases. Our presented child case had extra cranial complication [Frontal sub scalpular abscess and orbital cellulites], commonly associated with epidural abscesses[13,16]. Epidural abscesses progress slowly than subdural empymas[10,17] and are diagnosed early [by showing extra cranial complications] hence have better outcomes in management, was found in the series[11,14,16]. By contrast, the subdural empyna spreads rapidly and freely within a preformed space, typically resulting in a more culminant acute presentation with early neurologic deficits [as in our adult case]. “Silent” intracranial involvement is common, especially in children[13,14,16] and our child case also showed no neurological deficit. Though an antrum lavage was done in the affected child but still he had complications, justifying that a high index of suspicion for concurrent ICS must be maintained when sinusitis fails to respond to therapy. CT scan and MRI are more accurate for localizing the subdural empyma[13] and a MRI is superior to a CT scan in localizing the intracranial collections, as in our adult case. Functional Endoscopic Sinus Surgery [FESS] is indicated in nearly all the patients [even who do not require neurosurgery because of small or thin collections] as it gives favorable outcomes and low morbidity. In our cases, only external exploration for sinuses was done, as we have no FESS facility. In another series[11] of 23 patients with ICS, Twenty two patients (96%) had radiologic evidence of frontal sinusitis with prefrontal or frontal lobe ICS at presentation suggesting that Intracranial complications of sinusitis usually result from direct spread of acute frontal sinusitis Endoscopic sinus surgery and intravenous antibiotics as initial treatment was successful in avoiding craniotomy in only 1 of 6 patients again suggesting that ESS did not appear to alter the need for neurosurgical intervention, which was ultimately necessary in most patients hence the role of ESS in the initial treatment of ICS is not clear. In this series of 23 patients, 18 underwent neurosurgical procedures, 9 for emergent procedures for abscesses more than 1 cm and 9 underwent delayed procedures for persistent disease despite ICS less than 1 cm at presentation.
Cranial Complication of Sinusitis

On culture of pus from our cases, Gram’s positive bacteria were seen as in series[4] where gram positive multiple organisms grew in 54% of patients [predominated Streptococcus milleri group and Staphylococci A coagulase negative species]. The intracranial complications of sinusitis are serious and source of important morbidity and mortality. Management should be rapid and adequate, combining effective antibiotic therapy and eventually neurosurgical treatment[1,3,7], Table 1-4

Table 1: Review for symptoms, signs and its duration.

<table>
<thead>
<tr>
<th>Clinical presentation and the disease course (depend upon the site of lesion)[10].</th>
<th>The presented cases, to start with, had no specific symptoms like – high fever, headache, and nausea though later both had signs of raised intracranial pressure, the common neurologic symptom being a change of mental status [disorientation]. In past history- the child case [with meningitis only] had no symptoms and signs of sinusitis but the adult case [advanced stage of ICS] had a history of frequent rhinosinusitis with blood mixed mucopurulent nasal discharges and in signs, had tender sinuses.</th>
<th>Similar non specific presenting symptoms were found in most series of studies[5,8] and in advanced stage of complications neurological signs and symptoms were the most frequent along with rhinological presentation like purulent rhinorrhea and nasal obstruction][7], The duration of symptoms The duration of symptoms in our cases was 3 days [average]. The duration of symptoms was stated to be 12 days in average in other studies[3].</th>
</tr>
</thead>
<tbody>
<tr>
<td>The duration of symptoms</td>
<td>The duration of symptoms in our cases was 3 days [average].</td>
<td>The duration of symptoms was stated to be 12 days in average in other studies[3].</td>
</tr>
</tbody>
</table>

Table 2: Review for prior sinus surgery, extra cranial extensions, neurological deficits and the hospital stay.

<table>
<thead>
<tr>
<th>Prior history of sinus surgery</th>
<th>Both the cases had no such history</th>
<th>Similarly no such history was found in a comparative study of different series by Griller et al[9].</th>
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</thead>
<tbody>
<tr>
<td>Extra cranial extension of ICS</td>
<td>The child case [not in adult case] with intracranial epidural abscess had extra cranial extension like frontal sub scalpular abscess and orbital cellulites. Extra cranial extension is commonly associated with epidural abscesses[13,16].</td>
<td>“Silent” intracranial involvement is common, especially in children[13,14,17].</td>
</tr>
<tr>
<td>Intra cranial infection and neurological deficit</td>
<td>The child case showed no neurological deficit as he had a “Silent” intracranial involvement but the adult case had neurological deficit.</td>
<td>“Silent” intracranial involvement is common, especially in children[13,14,17].</td>
</tr>
<tr>
<td>Hospital stay of patients with ICS</td>
<td>The hospital stay was 28 days for the adult and 14 days in the child case</td>
<td>Similar stay of 15 - 30 days was noticed in other studies too[9,14].</td>
</tr>
</tbody>
</table>

Table 3: Review for the site of Lesion, role of radiology and treatment.

| Site of Lesion | The adult case had a subdural empyema and the child case had an epidural abscess. Both the cases had Fronto-Ethmoido-Maxillary sinusitis on the affected side. Subdural empyma has been reported as a common site in all Intra cranial suppurations due to sinusitis[11,12,10] and epidural abscess was seen as a common ICS, in series with children[14,9]. Frontal sinusitis was the commonest cause of epidural abscess in adults and children[14,15]. | Many studies advocate that a high index of suspicion for concurrent ICS must be maintained when sinusitis fails to respond to therapy[14,16]. Similar were the findings[15] that CT scan and MRI are more accurate for localizing the subdural empyma and a MRI is superior to a CT scan in localizing the intracranial collections, Similar drainage of the abscesses [intra cranial, by neurosurgeon and involved sinuses by otolaryngologist] made most patients recovered to premorbid state without neurological sequelae[6], |
| CT scan and MRI | CT scans were done for both the cases and a MRI was also done for the adult case. Similar were the findings[15] that CT scan and MRI are more accurate for localizing the subdural empyma and a MRI is superior to a CT scan in localizing the intracranial collections, | Many studies advocate that a high index of suspicion for concurrent ICS must be maintained when sinusitis fails to respond to therapy[14,16]. |
| Role of treatment on progress of ICS | An antrum lavage [in child case] and broad spectrum antibiotics [in both cases] could not control ICS. In both the cases the sinus abscesses were drained along with that extra cranial [in child] and intra cranial [in adult] and both recovered without any neurological sequelae. | Many studies advocate that a high index of suspicion for concurrent ICS must be maintained when sinusitis fails to respond to therapy[14,16]. |

Table 4: Review for the progress of the disease.

| Progress of the disease | In the child case [epidural abscess] the disease progressed slowly and was diagnosed early by showing the extra cranial complications. In the adult case [subdural empyma]- the spread was rapid and had a more culminant acute presentation with early neurologic deficits | Epidural abscesses progress slowly than subdural empymas and are diagnosed early[13,16] hence have better outcomes in management[11,14,16]. -Subdural empyma spreads rapidly and freely within a preformed space so it has a more culminant acute presentation with early neurologic deficits[10,17]. |

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