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**Occipital Epidural Abscess with Sinus Phlebitis Due to Chronic Osteomyelitis**

By


With 3 Figures

**Summary**

We report an unusual case of occipital osteomyelitis originating from an old scalp wound, and causing subsequent sinus thrombosis and an epidural abscess. This is the first such case reported. The mechanism of the symptoms and the literature are discussed.

*Keywords*: Occipital osteomyelitis; epidural abscess; staphylococcus epidermides; sinus phlebitis; intracranial pressure.

**Introduction**

Epidural abscess secondary to osteomyelitis of the skull caused by various organisms has been reported by only a few authors. However, there is no report of a case where sinus phlebitis is an additional complication of this disease process.

We report a case of occipital osteomyelitis, epidural abscess and sinus phlebitis in a patient who experienced an occipital subcutaneous abscess 52 years ago.

**Case Report**

This 58-year-old female was admitted to the Department of Neurosurgery, Shinshu University Hospital on May 23, 1981, with chief complaints of nausea, vomiting and headache. She had had no recent trauma. She had a history of a small occipital subcutaneous abscess when she was 6 years old, which was opened and drained at a hospital elsewhere. There was no report about the bacteriological cause of the abscess. Postoperatively the wound apparently healed. She had been well since then until one month prior to the present admission, when her symptoms appeared.
Examination. A fluctuant swelling 2.5 cm in diameter was palpable in the midline occipital region. On the surface of the swelling an old scar was recognized with a small dimpling from which a yellowish discharge came out on pressing. She had bilateral papilloedema but no other neurological deficits. Roentgenograms of the skull showed areas of irregular radiolucency in the occipital and parietal bones and there were no findings suggesting old or recent fractures (Fig. 1). The Computer tomography (CT) scan showed a low density area in the left occipital region close to the midline and just above the inion (Fig. 2). The left carotid angiogram revealed an avascular area in the occipital region; the transverse and straight sinuses were stenosed and the sagittal sinus was obstructed (Fig. 3). The temperature on admission was 36.8 °C; the blood pressure was normal and the laboratory data were within normal ranges except the high ESR value of 43–100.

Operation. On May 27, 1981 the patient was operated on. A vertical skin incision was made in the left occipital area 1.5 cm lateral to the midline and above the inion, where the CT scan indicated a subdural mass. When a burr hole was made, thick pus came out from the epidural space and bone edge. The skin incision was then extended around the subcutaneous abscess and a large craniectomy was performed until normal bone edge was encountered. The infected bone was hypertrophic and soft and its surface was irregular with some small pores. The dura beneath the invaded bone was thick and there was no bleeding from the exposed portion of the sagittal sinus. The subdural pus was found spreading