

A Case Report: Massive Subdural Empyema Following Ventriculo-Peritoneal Shunt Placement in Child Patient

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Abstract

Background: Subdural empyema is a critical neurosurgical condition that arise from neurosurgical procedures, trauma, meningitis, sinusitis, or otogenic infection. Reported mortality rates vary from 4.4% to 24%. Ventriculoperitoneal (VP) shunt placement is one of the most common procedures and reported rates for shunt infections are relatively high. However, their association with subdural empyema is rare.

Case Report: One years old boy who presented with fever, lethargy, and inability to walk was admitted to the hospital. He was undergone Vp-shunt 1 month ago because of hydrocephalus. At the time of admission, the child was alert, had a moderate right hemiparesis, and a macrocephalic appearance. An emergency CT scan showed well-circumscribed subdural empyema.

Discussion: A craniotomy was performed, then thick fibrous capsule underlying the dura mater was encountered, finally the pus was totally removed. Postoperatively, he was fully alert with a marked motoric improvement. Diplococcus gram positive was found. The patient was given appropriate antibiotic treatment for 3 weeks periode.

Conclusion: Subdural empyema is an unusual complication of a VP-shunt. Although rare in children, it is still a neurosurgical problem. The combination of medication and surgery treatment in Subdural empyema resulted in a good response.

Keywords: Subdural Empyema, Pediatric, VP-Shunt, Infection

Introduction

Subdural empyema (SDE) is a collection of purulent material between the dura mater and the arachnoid mater that usually occurs secondary to middle ear infection, meningitis, brain surgery, paranasal sinusitis, head trauma, or via hematogenous spread [1][2]. SDE is a critical neurosurgical condition that has mortality rates vary from 4.4% to 24% [1][2]. Ventriculoperitoneal (VP) shunt placement is one of the most common procedures in neurosurgery. The occurrence of SDE as a complication of a ventriculoperitoneal (VP) shunt infection is rare. Moreover, the reported rates for shunt infections are relatively high[3][4]

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Case Report

One years-old boy who presented with fever, lethargy, and inability to walk since 1 weeks before admission at the hospital. He was undergone ventriculo-peritoneal shunt 1 month ago because of hydrocephalus. At the time of admission, the child was alert, had a moderate right hemiparesis, and a macrocephalic appearance with a head circumference of 52.5 cm. Head CT-scan was seen ini figure 1 and figure 2.

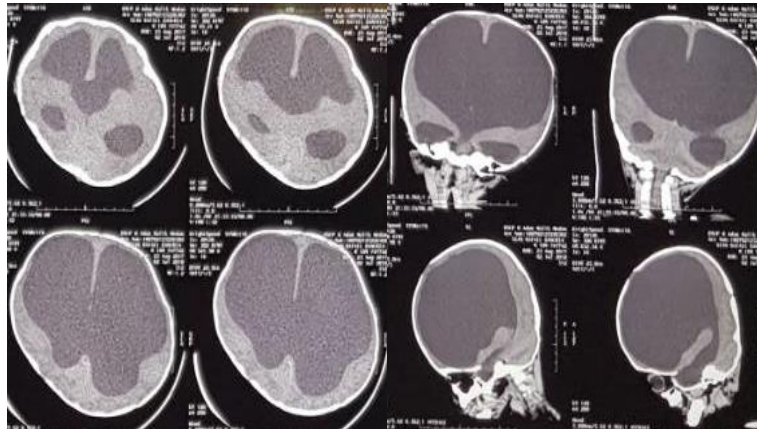


Figure 1. Non-Contrast Head CT-Scan of Patient before VP-shunt Procedure

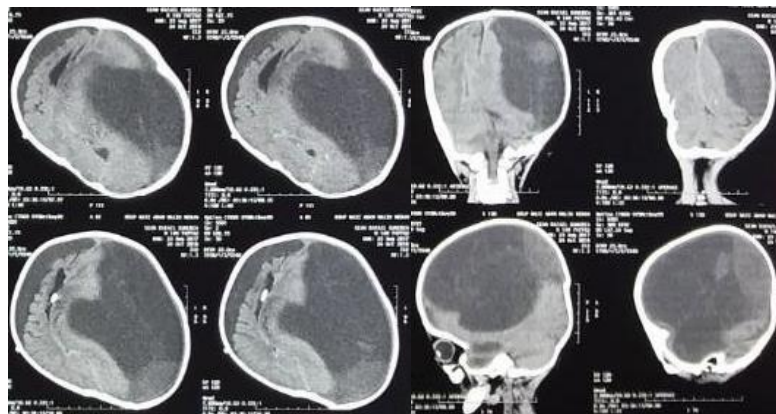


Figure 2. Non-Contrast Head CT-Scan of Patient 1 Month after VP-shunt Procedure

A craniotomy was performed in this patient. The duramater was opened and a thick fibrous capsule underlying the duramater was encountered. The pus was totally removed. Fully intraoperative view would see at figure 3. Post operative patient with GCS 15 and improvement in paresis (figure 3).

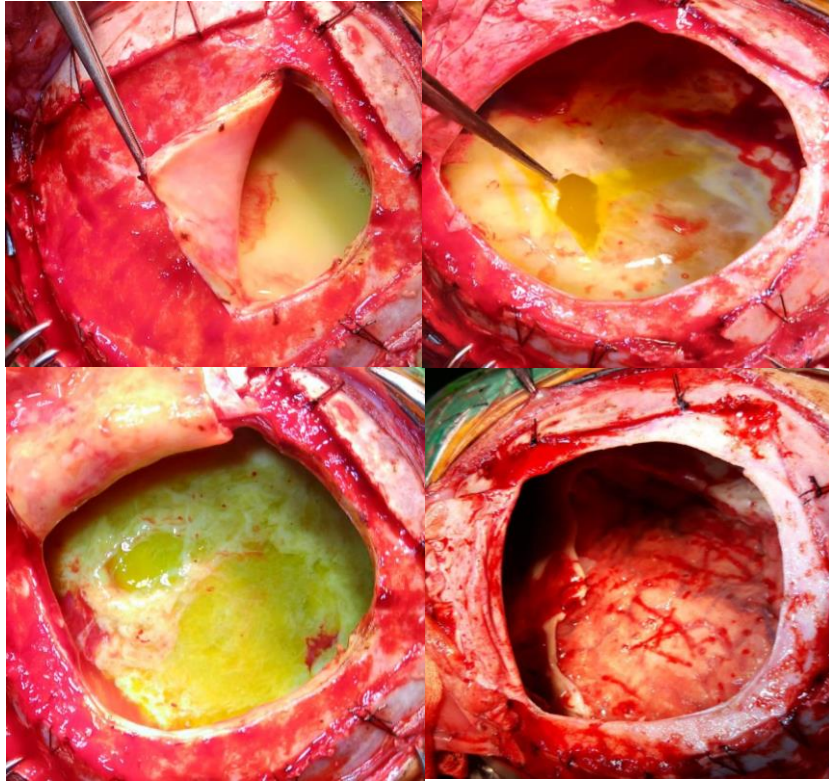


Figure 3. Intraoperative View

Discussion

Ventriculoperitoneal (VP) shunt placement is one of the most common procedures in neurosurgery [5][6]. This hydrocephalus treatment is often complicated by infection. However, subdural empyema is rare complication after following this treatment [7][8]. Intracranial subdural empyema may cause headaches, fevers, altered mental status, motor deficits, and seizures. A VP-shunt infection is typically diagnosed after a workup that includes a CT head, a shunt series, and shunt reservoir tap [9][10]. Our patient presented at hospital with fever, lethargy, and inability to walk after had a Vp-shunt procedure 1 month ago. Based on non-contrast Head CT-Scan shows a right hemispheric calcified empyema then performed craniotomy and pus was totally removed. Diplococcus gram positive was found from the pus. The patient was given appropriate antibiotic treatment with levofloxacin and metronidazole for 3 weeks periode. he was fully alert with a marked improvement of the left hemiparesis after combination treatment, definitive antimicrobial therapy and surgical procedure.

Conclusion

Subdural empyema is an unusual complication of a VP shunt. Although rare in children, it is still a neurosurgical problem. Possible etiology may be local wound infection that seeds the subdural space and travels to the cranium, leading to meningitis and subdural empyema. This case demonstrates that Subdural empyema may reach a giant size and thus may mimic an intra-axial lesion in emergency axial CT scans. The combination of medication and surgery treatment in Subdural empyema resulted in a good response, fully alert with a marked improvement of the left hemiparesis.

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