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*Picture Quiz - Answer*

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Dear Editor

I was disappointed to read, in the case scenario of a recent article regarding the investigation of a patient with polyarthritis<sup>1</sup> that a patient was not offered an HIV test despite there being clinical indication. The reason given was the absence of risk factors.

In order to reduce the chance of missing a diagnosis of HIV based on an over reliance on patient reported lifestyle, guidance has been put in place. The British HIV Association<sup>2</sup> (BHIVA) offers a comprehensive guideline on HIV testing and all doctors should be capable of asking a patient to have an HIV test and explaining why.

Estimates suggest that there are approximately 21,000 undiagnosed people with HIV living in the UK.<sup>3</sup> Each undiagnosed person is potentially a source of infection for others. To counter this number of undiagnosed people we should be testing more often and de-stigmatizing HIV testing.

A culture of stigma surrounding HIV and HIV testing means we cannot be sure that our patients will feel comfortable to be open with us about risk factors. Until HIV testing becomes more routine

we cannot rely purely on verbal reports of patient behaviour regarding risk factors when we cannot be sure patients disclose all the relevant information. Additionally patients may be unaware that they have been exposed to risk of HIV and so testing when indicated should be an essential part of the work up of any relevant condition.

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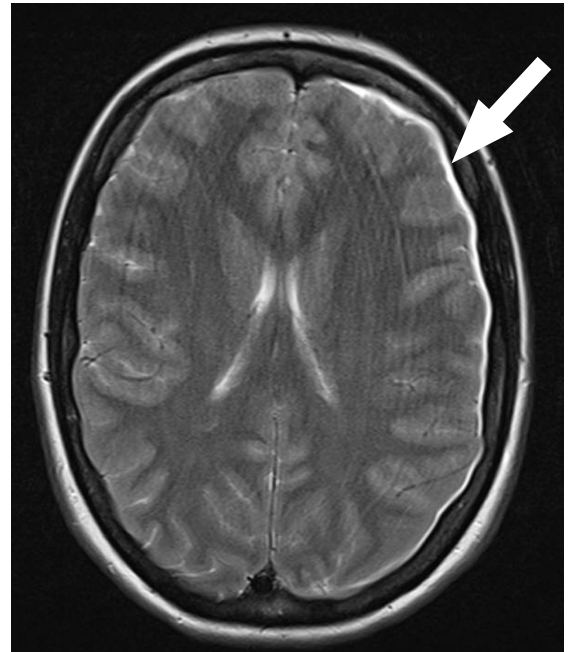
## Picture Quiz - Answer

Dear Sir,

I read with interest the article in the last edition of *Acute Medicine*, which highlighted the importance of awareness of best practice when performing a lumbar puncture (LP) for investigation of neurological symptoms on the acute medical unit.<sup>1</sup> The decision to undertake LP is a key challenge for acute physicians, particularly when there are no 'red flag' symptoms or signs. The benefits of the procedure always need to be balanced against the risk of significant complications, as highlighted by a recent case in our unit.

A 21 year old woman presented with four days of flu like illness, comprising sore throat, cough, myalgia, frontal headache and photophobia. On neurological examination there was neck stiffness but negative Kernig sign and normal fundoscopy. An initial diagnosis of viral infection was made, but a lumbar puncture was deemed to be necessary in order to exclude meningitis. The lumbar puncture was traumatic, leading to large numbers of red blood cells on cerebrospinal fluid (CSF) analysis; the presence of xanthochromia could not be determined as the sample was insufficient. A CT brain scan was performed after the LP results, which revealed no radiological evidence of subarachnoid haemorrhage. Polymerase chain reaction testing of CSF was negative for herpes simplex, varicella and enterovirus infection. 24 hours after the lumbar puncture the patient's condition deteriorated with more severe headache, vomiting and orthostatic symptoms. These symptoms failed to settle, and cerebral magnetic resonance imaging performed on day 4 post lumbar puncture revealed a small subdural haematoma in the left cerebral hemisphere (Figure1). She was transferred to the regional Neurosurgical Unit where CT angiography excluded any vascular abnormality. The patient was treated with a blood patch and her symptoms gradually resolved.

Orthostatic headache following dural puncture is an important complication and results from CSF hypotension.<sup>2</sup> Subdural haematoma is a rare, but recognised complication following lumbar puncture.<sup>3</sup> Acute physicians need to be aware of the potential for significant complications following



**Figure 1.** MRI scan showing shallow subdural haematoma (arrow)

LP; early recognition and treatment is important. Following evidence of a large number of blood patches being required following lumbar puncture in our unit, we have adopted the use of narrow gauge spinal needles which have been shown to reduce the incidence of post-LP headache.<sup>4</sup>

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