

An Acute Severe Headache

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Case History

A previously fit and healthy 57 year old gentleman presented to hospital 2 weeks after a previous admission with acute severe headache. At the time of his previous admission the patient had reported that the headache was preceded by an unprovoked sharp pain in his back which had quickly resolved. The headache developed a few hours later and was noted to be markedly worsened by any attempt to sit upright, accompanied by intense nausea, and relieved by lying flat. He admitted to regular vigorous weight lifting and occasional use of anabolic steroids. Examination at the time of his first admission was unremarkable with no signs of meningeal irritation, no pyrexia and normal fundi. There was a mild neutrophilia and (neutrophils 10.3) but other blood tests including CRP were normal. A CT brain scan and subsequent cranial MRI were entirely normal and he was discharged, without the need for a lumbar puncture, with a clinical diagnosis after review by a neurologist.

Although there was initial improvement in the headache following discharge from hospital, the pain subsequently increased in intensity, again worsened by any upright posture. A repeat cranial MRI scan was undertaken (Figure 1 and 2).

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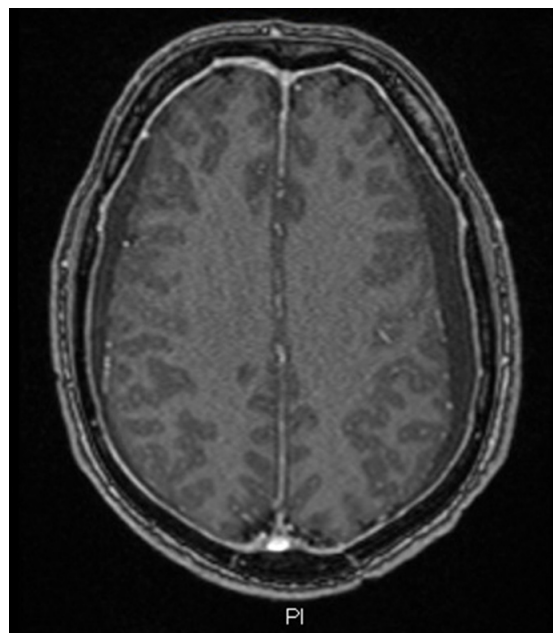


Figure 1.

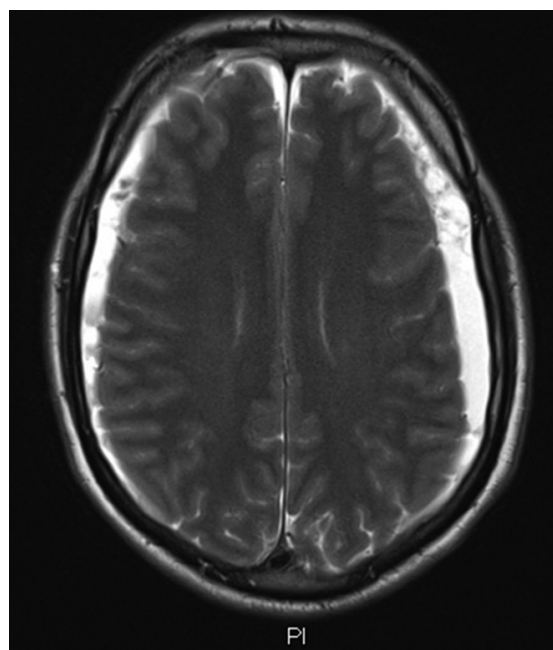


Figure 2.