Letters

Solitary caecal diverticulitis

Editor,

I have had recent experience of three cases of solitary caecal diverticulitis which presented over an 18 month period to Causeway Hospital[1] and wished to add to the case by Abogunrin *et al*.[2] There have been over 1000 cases of caecal diverticulitis reported in the literature. A review of 881 cases showed that the average age was 43.6 years (range 7 to 87 years) with a 3:2 male to female ratio.[3] 85% present with symptoms similar to appendicitis.[3] Cutajar[4] suggested clinical features which could help differentiate caecal diverticulitis from appendicitis. There is a relatively long history of abdominal pain with lack of toxicity. Tenderness is not as marked and only elicited on deep palpation, and vomiting is less frequent. Abogunrin *et al*[2] suggested that CT scanning was the most useful pre-operative investigation as ultrasound was not sensitive. However, Chou[5] proved the accuracy of ultrasound in diagnosing caecal diverticulitis. In a prospective study of 934 men with indeterminate right lower abdominal pain, ultrasound had a sensitivity of 91.3% and a specificity of 99.5% in differentiating right sided diverticulitis from appendicitis. Ultrasound also has the advantage of avoiding radiation exposure and being generally more accessible. Given the low incidence and difficulties with diagnosis, there have been no randomised trials comparing conservative with aggressive treatment. Most studies are retrospective note reviews comparing outcomes in those treated with antibiotics alone to diverticulectomy or hemicolectomy, and also tend to be from mainly Asian populations, which may not be truly representative of the UK.

Lane *et al*[6] in a study of 49 patients with 78% of non-Asian descent, found that 40% of those treated with diverticulectomy or antibiotics alone required subsequent hemicolectomy due to an ongoing inflammatory process. In a US population, they recommended diverticulectomy in cases of a solitary inflamed diverticulum. Our cases, treated with diverticulectomy or inversion of the diverticulum had no postoperative complications or recurrence of symptoms. We agree with Abogunrin *et al*[2] that surgery should be conservative when carcinoma is excluded and there is not extensive inflammation.

The author has no conflict of interest

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Benign Headache in the Elderly – A Case Report of Hypnic Headache

Editor,

New headaches in the elderly raise the suspicion of serious pathology such as space occupying lesions, temporal arteritis, or cerebrovascular disease. Alternatively such headaches may simply represent the re-emergence of a previous headache such as migraine. However, benign headache syndromes are increasingly being recognised in this population.

The Hypnic Headache Syndrome (HHS) is a rarely reported disorder of the elderly characterised by recurrent nocturnal headaches of moderate severity that waken patients in a predictable pattern.

Case Report A 79 year old man had a four week history of headaches occurring predictably 2-3 hours after falling asleep and lasting for about one hour, during which time he sat up believing that this relieved the headache. This recurred every night, once or twice per night, with no daytime headache. He described it as a 'choking, full' headache, distributed 'like a cap'. It was associated with mild nausea but no vomiting or other autonomic features. There was no previous history of headaches.

Past history included ischaemic heart disease, a previous basal ganglia lacunar infarct, controlled epilepsy, hypertension, osteoarthritis, diverticulosis, prostatic hypertrophy, peripheral vascular disease and chronic renal impairment. Examination was normal.

Initial investigations revealed creatinine 134, sodium 129. Hyponatraemia was felt secondary to carbamazepine; a synacthen test and thyroid function were normal. Sodium subsequently normalised. Chest X-ray was normal and a CT scan of Brain showed mild cerebral atrophy and the previous infarct. Other investigations included a normal US abdomen/pelvis, normal CT chest/neck, normal FBP, Liver function tests, C reactive protein, CEA, CA19.9, PSA and urinary catecholamines.

Based on the above we diagnosed Hypnic Headache Syndrome and commenced the patient on 200mg lithium carbonate. Within 48 hours there was sustained complete resolution of the headache. After discharge the general practitioner discontinued the lithium because of concerns about drug interactions, and the headaches returned. Simple analgesia was substituted but headaches continued.

DISCUSSION

Hypnic Headache is a benign nocturnal headache which predominantly affects elderly people. This case illustrates some classic features of the syndrome. Evers and Goadsby[1] reviewed the 71 reported cases giving us the clearest picture of the syndrome to date. 37% were male and 63% female. Mean age of onset was 63 +/- 11 years (range 36-83). Headache was described as: Moderate - 67%, Severe - 31%; Dull - 57%, Throbbing/Pulsating - 38% and Sharp/Stabbing - 5%; Diffuse - 57%, Frontotemporal - 42%, Posterior - 1.6%. Average duration was 67 +/- 44 minutes (range 15-180). Onset was 60 - 120 minutes after falling asleep in 77%. Nausea was reported in 19%. The pathophysiology of HHS is currently theoretical, but associations with the sleep/wake cycle and circadian rhythms form the basis for theories of its nature. Polysomnography has revealed the onset of hypnic headaches may be associated with REM sleep.[2] It may be that inactivation of antinociceptive structures, e.g. dorsal raphe, during REM mediates the headache.[3]

Commonly patients experience the headache at a predictable time each night, suggesting a link with the circadian rhythm, which is orchestrated by the suprachiasmatic nuclei in the hypothalamus (also involved in antinociception). These nuclei produce, among others, melatonin, an important mediator of circadian rhythm. With advancing age the function of the hypothalamus, and thus melatonin secretion, is impaired.[4] This could also be involved in the pathogenesis of hypnic headache. Lithium is believed to increase melatonin levels[5] and may explain its mode of action. However, undoubtedly it is more complex than any one of these associations as many different drugs have been tried with variable success. Lithium remains the most effective but is often limited by side effects and interactions, and requires monitoring of plasma concentrations to avoid toxicity. Other reported treatments include indomethacin, caffeine, verapamil, prednisolone, gabapentin, melatonin, and acetazolamide.

Awareness of benign headaches is important to avoid unnecessary investigation but it must be stated that brain imaging and routine biochemical/haematological investigations are usually indicated when presented with new onset headaches in the elderly.

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Myopathy, hypokalaemia and pica (geophagia) in pregnancy

Editor,

Pica describes the persistant ingestion of nonnutritive substances.[1] Geophagia describes pica of clay.[2] We present a case of geophagia resulting in hypokalaemic myopathy.

Case History: A 29 year Gravida 3 Para 2 presented to a tertiary referral centre in Cape Town, South Africa, at 30^{+4} weeks gestation. She gave a two week history of photophobia, vomiting and weakness of the left side of her body. No other symptoms were reported. Fetal movement was reported to be normal. Her two previous pregnancies, in 1997 and 2001, were uneventful and resulted in normal vaginal deliveries at term. She had no significant medical or family history, was not on medication and did not report any allergies. She was a non-smoker and non-drinker. She was from the coloured community in Cape Town. She was a single mother, lived in an informal dwelling settlement, and had no monthly income.

She booked at 22 weeks gestation and an anomaly scan reported no fetal abnormality. Her booking Body Mass Index was 33, BP 110/85 mmHg, Hb 9.3g/dl, blood group A+ve, no abnormal antibodies, VDRL negative and HIV negative. Her pregnancy was uneventful up until presentation at hospital.

Examination of the cardio-vascular, respiratory and gastro-intestinal systems was normal. Neurological assessment of the central nervous system was normal. Proximal muscle strength was reduced bilaterally with muscle groups demonstrating 4/5 strength. Biceps and patellar reflexes were reduced and plantar reflexes were normal. Sensation was normal. The provisional diagnosis was a myopathic process of unknown aetiology.

Haematological investigations showed a Hb of 9.9g/dl, WCC 11.2×109/L, Platelets 391×109/L and an ESR of 73mm in 1 hour. Biochemistry showed a sodium of 145mmol/L, potassium 1.5mmol/L, urea 2.2mmol/l, and creatinine 116µmol/L. Liver function tests were also abnormal. Her creatine kinase was 9920U/L. Further investigations as an in-patient included and EMG, MRI scan of brain and muscle biopsy. The EMG reported features in keeping with a myopathy. The MRI scan and muscle biopsy were normal. Biophysical assessment of the fetus was reassuring.

Further questioning of the mother revealed that throughout the pregnancy she had regularly been eating clay from outside

