an early report. The operation of selective proximal vagotomy is clearly of great interest and requires further careful assessment; it would be wise, however, for surgeons to await the results of further trials before carrying out many of these operations without gastric drainage.

We are grateful to Sister Sturrock, who has helped in the care of these patients, and to Professor H. Ellis, Mr. E. Harper, Mr. R. Fiddian, and Mr. D. H. C. Harland for referring some of the patients to us.

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MEDICAL MEMORANDA

Spontaneous Spinal Subdural Haematoma

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Spinal subdural haematoma is one of the rarer causes of acute spinal compression and is usually associated with injury or a bleeding diathesis (Stewart and Watkins, 1969).

A case is presented here in which the spinal subdural haematoma had no apparent cause. Operative removal of the haematoma alleviated the patient's serious plight.

Case Report

A woman aged 63 gave the history of violently severe sudden pain in the arms, back, and abdomen just before retiring to bed 18 days before her admission to this department. Next day she was aware of weakness and numbness of the lower limbs and the bladder had to be catheterized. After five days of nursing at home she was taken to her local hospital, where lumbar puncture yielded bloodstained fluid with xanthochromic supernatant containing 800 mg of protein and 20 mg of sugar per ml. C.S.F. pressure was 45

mm of C.S.F., with no rise on jugular compression. Power and sensation in the legs improved for three days but the neurological condition of the legs deteriorated again, the abdomen was distended, and she was sent to the neurosurgical unit.

On admission there was severe flaccid paraparesis with virtually no hip or ankle movement. She was able only to wiggle her toes. The tendon reflexes were present and equal and the plantar responses extensor. There was a sensory level to pin-prick at the eighth dorsal level. Position sense and vibration sense were absent in the lower limbs. X-ray pictures of the spine showed slight arthritic changes but no other abnormality. The peripheral blood picture was normal. Lumbar puncture produced distinctly brownish fluid under a pressure of 100 mm of C.S.F., with no rise on jugular compression. Myelography showed a block to the flow of the contrast medium at D 8 and an irregular filling defect between D 8 and D 12 (see Fig.).

Laminectomy was performed on the day of admission, extending from D 8 to D 12 inclusive. The dura was tense and bluish, and when incised along the midline clotted old blood was extruded immediately. A soft rubber catheter passed freely upwards and downwards in the subdural space and no further clot was found. The spinal cord appeared normal and the subarachnoid space contained no blood within the limits of the exposure. No visible source of subdural haemorrhage could be seen.

Improvement in movement and sensation of the lower limbs began on the second postoperative day. She was discharged on the fourteenth day with voluntary control of micturition. Six months after operation she could walk with a walking frame. A year after operation her lower limbs became spastic and 17 months after operation bilateral obturator neurectomy was performed to correct spasm of the femoral adductors. At the time of writing she was able to get about with her walking frame.

Comment

Haematomas without apparent cause are uncommon. One of the cases described by Ainslie (1958) was similar to the present case. One can only surmise that the bleeding was caused by such minor trauma that it was not remembered by the patient. The remittent clinical course is reminiscent of intracranial subdural haematoma. The operative findings came as a surprise to us, but we now think that the history of sudden agonizing pain with bilateral radiation along several roots followed by paraparesis with a partial remission should suggest the clinical diagnosis of intraspinal haemorrhage. Such a diagnosis would be supported by the finding of altered blood on lumbar puncture and the myelographic finding of a block with an irregular extramedullary filling defect below it.

In spite of the long history of spinal compression and the very poor neurological condition on admission a worthwhile clinical result was obtained by laminectomy and evacuation of the haematoma.

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Myelogram showing partial block to the flow of contrast medium at D 8 and an irregular filling defect between D 8 and D 12.

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