

Case #1

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This 19-year-old white male sustained a severe comminuted open left fronto-temporal-maxillary-orbital-basilar skull fracture in an auto accident in Mississippi. The same day, he had a left frontal craniotomy, removal of epidural and subdural hematomas, debridement of brain lacerations, repair of dural tears, reapproximation of bone fragments, instillation of a Silastic orbital floor stint, suture of lacerations and a reapproximation of his left ear. Following surgery, he was placed on intravenous ampicillin and IM Kantrex as well as IM dexamethasone. Seven days after surgery, the patient began having spiking fever to 101° and his left para-orbital tissues became indurated, red and tender. CSF examination disclosed no bacteria and bacterial cultures were negative. The patient became more toxic. The sutures were removed from the wounds on the ninth post-operative day and drains were instilled which did not drain much. On the tenth post-operative day, the Silastic stint was removed and seropurulent material was sent for culture. On the 12th day, his left eye was enucleated and the multiple bone fragments removed. His wound did not bleed, appeared dark and necrotic and relatively avascular. Brain tissue appeared to be herniating into the orbit.

This patient responded to surgical debridement and therapy with a total of 3.2 grams of amphotericin B. He is alive and doing well.

Microscopic Pathology: The eyeball showed panophthalmitis and ischemic necrosis of the retina secondary to the orbital infarctions. Portions of cerebral cortex within the biopsy showed similar inflammation and necrosis. The H & E slide submitted was prepared from the orbital tissue.

Point for Discussion:

1. Diagnosis.