we have no definite proof of a causal link between the suction and the clinical deterioration in this case, the sequence of events and the rapidity and severity of deterioration would support our hypothesis. Although the case is not proven, the clinical link is compelling and the consequences were devastating. We feel that it is important to draw attention to this potential complication of nasogastric feeding.

Conclusion

Currently there are no guidelines regarding stopping nasogastric feeds whilst oropharyngeal suction is carried out. Discussions with nursing, physiotherapy and intensive care colleagues revealed that rechecking the position of the nasogastric tube after oropharyngeal suction is not common practice. We suggest that nasogastric feeding should be stopped during oropharyngeal suction and the tube position should be checked every time an oropharyngeal suction is performed.

Key points

- Nasogastric feeding should be stopped during oropharyngeal suction.
- The position of the nasogastric tube should be checked every time an oropharyngeal suction is performed.

Conflicts of interest

We confirm that there are no conflicts of interest.

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Giant cell arteritis presenting as peri-orbital ecchymosis

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Abstract

Neuro-ophthalmic manifestations are common in giant cell arteritis (GCA) and sometimes may be the only presenting feature. Clinicians should be aware of typical and atypical features of GCA in order to intervene in time before permanent damage occurs.

Keywords: *giant cell arteritis, peri-orbital ecchymosis, elderly*

Case report

A 77-year-old lady was admitted with spontaneous bruising (ecchymosis) around the left eye. She was a diabetic and hypertensive and was not on any anti-thrombotic drugs. Detailed history revealed sudden onset right-sided headache (contralateral side) and jaw claudication. She had no visual or systemic symptoms.

Examination showed bilateral tender and nodular temporal arteries and ecchymosis around the left orbit. Ophthalmological examination was normal. Erythrocyte sedimentation rate (ESR) was 71 mm/hour and C-reactive protein was 180 mg/l. There were no signs or symptoms suggestive of an infective or an inflammatory focus elsewhere.

A diagnosis of giant cell arteritis (GCA) was made and she was commenced on high-dose prednisolone. A biopsy of the temporal artery on the left side confirmed the diagnosis. Her symptoms and her inflammatory markers settled very rapidly and she continues on a tapering course of steroids.

Discussion

Neuro-ophthalmic complications are common in GCA and are seen in approximately 70% of patients. Peri-orbital manifestations (Table I) are uncommon and can lead to a delay in diagnosis. Clinicians should be aware of typical and atypical features of GCA in order to intervene in time before permanent damage occurs.

Table 1. Orbital/peri-orbital features of GCA[1-6]

Orbital infarction syndrome – acute blindness, ophthalmoplegia, orbital pain
Orbital pseudotumour – proptosis
Orbital apex syndrome – pain, proptosis, chemosis, restricted eye movements
Oedema around the orbit
Orbital inflammation – haemorrhagic chemosis, ophthalmoplegia, fever
Peri-orbital ecchymosis

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Orthostatic hypotension following acute intracerebral haemorrhage

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Abstract

Background: blood pressure regulation may be impaired following acute stroke. Typically, there is overactivity of the sympathetic nervous system and underactivity of the parasympathetic system resulting in transient hypertension. Orthostatic hypotensive responses in acute stroke are less well documented.
Case report: we present a case of severe persistent orthostatic hypotension (OH) following acute intracerebral haemorrhage in a previously fit and well man. Symptomatic OH persisted for 60 days post-stroke. No known causes of OH could be identified.
Conclusions: such profound and persistent orthostatic hypotension following an acute intracerebral haemorrhage has not previously been documented. The precise cause of this finding in the case described is unknown, but may have been due to impaired higher-level regulation of the autonomic nervous system. A conservative approach with prolonged physical methods proved successful in rehabilitating this patient without the need for pharmacological intervention.

Keywords: *hypotension, orthostatic, stroke, physiotherapy, elderly*

Case report

A 71-year-old right-handed male was admitted with an acute-onset right hemiplegia. His only past medical history was of glaucoma for which he was using carteolol eyedrops. He was an ex-smoker and consumed 28 units of alcohol weekly. He was fully alert with normal speech and no cranial nerve or visual field defects. Power was 0/5 in the right arm