Intravesical thermometer: an unusual complication of vaginal temperature measurement

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A 28 year old nulliparous woman presented to the accident and emergency department after failing to retrieve a glass mercury thermometer from her vagina. She had been using the thermometer to measure her vaginal temperature on waking each morning as part of a fertility programme in order to ascertain the time of ovulation. Although oral or rectal temperature measurements are usually used to estimate core body temperature, in this instance the patient’s general practitioner had recommended vaginal measurement as an acceptable alternative. In addition, specific popular health care books obtained by the patient had also recommended vaginal temperature measurements.

Initially digital and speculum examinations of her vagina were carried out—both were unremarkable. A plain radiograph of the pelvis was obtained. This clearly demonstrated the thermometer lying transversely within the urinary bladder. The patient was referred to the duty urologist who removed the thermometer via a rigid cystoscope under general anaesthesia without complication.

This is an extremely unusual case where a patient has passed a mercury thermometer per urethram into her bladder while attempting to obtain a vaginal temperature measurement. Although the vagina is an accepted site in which temperature readings may be obtained, it is quite clear that this case could have been avoided had oral or rectal measurements been preferred. In addition there can be no doubt that if, as suggested, measurements are taken immediately on waking before the patient is fully alert, misplacement of the thermometer is much more likely.

Infected chronic extradural haematoma

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A 17 year old man was referred to Torbay Hospital with a two week history of headaches. These were frontal and bitemporal in location, worse on coughing and leaning forward, and with a clear pattern of increasing frequency and severity. There was no history of trauma, no history of nausea or visual disturbance, and no family history of migraines. Physical examination revealed no evidence of meningism or localising neurological signs but fundoscopy showed slight blurring of the disc margins bilaterally. The patient was apyrexial and had a small tender soft tissue swelling over the right forehead. He was admitted for observation and investigation but soon after admission his headaches worsened and he started to vomit. Computed tomography of his head was performed urgently and revealed a calcified chronic right frontal extradural collection with some mass effect (fig 1). He was referred for urgent surgery at Derriford Hospital, Plymouth and underwent emergency frontal craniectomy with drainage of an infected extradural haematoma. *Streptococcus anginosus* was isolated from the

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**Figure 1** Computed tomogram of the patient’s head.

**Figure 1** Thermometer shown lying within the pelvis.
collection, the patient was started on intra-
venous cefotaxime and transferred back to Tor-
bay for further care. He received a total of three
weeks of intravenous antibiotics and, at follow-
up five weeks following surgery, his computed
tomogram had returned to normal and he was
symptom free. During his recovery, he recalled
an incident two years previously when he had
been struck on the head while playing football
and had lost consciousness. He did not obtain
medical help after this and had no post-
 concussion symptoms.

Extradural haematomas are normally the
result of trauma to the head and typically
present with signs and symptoms of rapidly
increasing intracranial pressure. The term
chronic extradural haematomas is usually
reserved for those haematomas that exist for
more than 13 days after trauma but there is no
precise definition. They represent 7% to
14% of extradural haematomas and, in
almost a quarter of patients, the cause is not
determined. Infection of the extradural space
is extremely uncommon but there is a recog-
nised association of extradural abscess forma-
tion with chronic sinusitis and with otitis
media. Secondary infection of a chronic extra-
dural haematoma is, however, unreported. S
anginosus, one of the Streptococcus milleri group
of organisms, is considered to be commensal
and is associated with abscesses and purulent
infections particularly affecting the cardiac,
abdominal, skin, and central nervous systems.

The organisms are usually sensitive to com-
mon antibiotics but surgical evacuation is usu-
ally necessary when there is abscess formation.

Our patient had a chronic extradural he-
matoma, which we assumed to be a result of his
head injury two years previously. The source of
his infection is not entirely clear but it is
conceivable that he had a transient bacteriae-
ma that resulted in colonisation of his haematoma. We recommend that when assess-
ing patients with a suspected space occupying
lesion, an extended history should be taken
looking for evidence of a traumatic origin.

Unusual cause of a raised right hemidiaphragm

V Inyang

A 31 year old woman was brought by
ambulance after a road traffic accident. She
had been the driver of a car travelling at 50
mph before collision with a tree. The paramed-
ics reported significant intrusion of the driver's
doors towards the patient's right chest wall.

On examination she had a tachypnoea of
24/min, diminished breath sounds in the right
lung base, and a pulse rate of 113/min. A chest
radiograph revealed a raised right hemidi-
aphragm (fig 1). The patient stabilised haemo-
dynamically with a 2 litre crystalloid infusion.

She was nursed on a high dependency unit
overnight.

Thoracoscopy in the morning was negative.
Abdominal computed tomography showed a
liver haematoma (fig 2). This presentation has
not been previously reported. The patient
made a good recovery with conservative
management.

In stable patients computed tomography
remains a valuable tool for the non-invasive
definition of pulmonary, diaphragmatic, and
abdominal visceral injury.

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3 Viljoen JJ, Wessels LS. Subacute and chronic extradural
4 Pistelli SC, Shwed J, Schreckenberger P, et al. Streptococ-
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Figure 1 Chest radiograph showing raised right
hemidiaphragm.

Figure 2 Computed tomography showing the liver
laceration (arrow).