been described as “a reckless disregard of danger to the health and welfare of the infirm person” (see *Andrews v DPP* [1937] A.C. 576 H.L. per Lord Atkins). The intellectual exercise required to justify withdrawal on the grounds of conscience is clearly a world away from recklessness and any indictment on such a charge would be quashed as an abuse of process.

Fittingly, a doctor will tend to be protected by the opinion of his colleagues. If there is divergent opinion as to the treatment options, then he may withdraw

knowing there are other doctors who will give treatment which his conscience cannot contemplate. If there is unanimity, it shows that he has almost certainly carried out the intellectual exercise in good faith.

Ultimately a doctor is safeguarded by the strength of his conviction and his intellectual honesty. It is very well established in law that he cannot be compelled to treat against his conscience. If that opinion is truly held, he must make it clear to the court. It will not bind the

court, but it is right that the judge should understand clearly that the treating clinician will not act against his conscience whatever the decision.

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IMAGES IN PAEDIATRICS.....

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Sinovenous thrombosis due to mastoiditis

A 9-year-old child presented with a 4-week history of headache, diplopia and mastoid pain. She was diagnosed with mastoiditis, received intravenous antibiotics and underwent mastoidectomy. Headache and diplopia persisted and the neurology service was consulted. Examination revealed right sixth nerve palsy and bilateral papilloedema. MRI demonstrated mastoid opacification and inflammation, and ipsilateral jugular and sigmoid venous sinus thrombosis (fig 1). The patient received low-molecular-weight heparin and acetazolamide, with prompt resolution of headache, diplopia and papilloedema.

Sinovenous thrombosis (SVT) is a known complication of acute mastoiditis,¹ and although the incidence of SVT has declined in the antibiotic era, it remains an important diagnostic consideration.^{2–4} In most cases, treatment of SVT includes aggressive hydration and anticoagulation, which has been associated with improved cognitive outcome and a trend to lower mortality³ without an increase in intracranial haemorrhage.^{3,4} The clinical improvement may occur long before the thrombosis improves on imaging and may be related to improved microcirculatory venous drainage. Delay in diagnosis and initiation of treatment with anticoagulation

may increase morbidity, including permanent visual deficits.

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Figure 1 (A, B) MR venography demonstrates signal void in the right sigmoid sinus and jugular vein (arrow). (C) T1 weighted MRI demonstrates opacification of the right mastoid (arrow) and the venous hyperintensity (dotted arrow) indicates that absent flow-related signal on venography is due to acute clot, not sinus hypoplasia.