Key points

- Superwarfarins may have toxic effects for weeks or even months.
- Toxic doses can be absorbed transcutaneously.
- High doses of Vitamin K are often required in treatment.
- Long term follow-up is required.

poisoning is unknown or withheld. Intentional poisoning as part of Munchausen's syndrome should be considered.¹

Patients with severe haemorrhage will require correction of their coagulopathy with fresh frozen plasma and vitamin K. In the absence of severe haemorrhage but abnormal clotting, vitamin K alone can be used. It should be given initially intravenously, and will be required in much higher doses (up to 125 mg/day) than in warfarin toxicity.⁴ Long-term oral vitamin K therapy and monitoring is necessary to avoid recurrence of symptoms and representation as in our case.

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IMAGES IN EMERGENCY MEDICINE

Pituitary apoplexy can mimic subarachnoid haemorrhage clinically and radiologically

Figure 1 T2-weighted axial magnetic resonance imaging scan showing a lesion in the pituitary fossa (arrow), displaying heterogeneous signal intensity suggesting recent apoplexy.

A 74-year-old man presented with a sudden onset headache, collapse, neck stiffness and photophobia. Extensive subarachnoid haemorrhage (SAH) with hydrocephalus was diagnosed on computed tomography. Negative cerebral artery angiography was carried out two times before he was discharged home 3 weeks later, having made a full recovery. About 15% of patients with SAH have no discernable cause of bleeding on angiography or other neuroimaging.¹

The patient was readmitted 8 months later with headaches and a gradual onset of bitemporal hemianopia. A magnetic resonance imaging scan showed a pituitary tumour (fig 1), and arrangements were made for urgent surgery. The day before his surgery, his condition deteriorated acutely, he complained of headache and nausea and was barely able to perceive light in either eye. He underwent emergency trans-sphenoidal hypophysectomy.

The presence of any visual disturbance (particularly of a bitemporal distribution) in conjunction with a sudden-onset headache is an important clinical pointer to the diagnosis of pituitary apoplexy rather than SAH.

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