literature or music can give an optimistic attitude. Additionally one can consume as much as one needs at any time, and there is no danger of “burning someone out.”

Conclusion

The most important companions for a patient with multiple sclerosis are probably family members and friends. They can give practical and psychological support in daily life. However, these activities are an enormous effort for them, and they may be at risk of expending all their energy and ending up burnt out.

If a patient has a clear view of the map and has good companions such as family, friends, and hobbies, which constantly reinforce the good news, the journey will be more pleasant for the patient and his surrounding.

“There is nothing in the world, I venture to say, that would so effectively help one to survive even the worst conditions as the knowledge that there is a meaning in one’s life.”³

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Interactive case report

Postoperative hypoxia in a woman with Down’s syndrome: case progression

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This is the second of a three part case report where we invite readers to take part in considering the diagnosis and management of a real patient using the rapid response feature on bmj.com. In three weeks’ time we will report the outcome and summarise the responses

Last week (9 April, p 834) we presented the case of Miss Webb, who has Down’s syndrome and had a sudden postoperative deterioration in her condition after a hysterectomy for menorrhagia. We invited readers to comment on the ethical issues around surgery and the possible cause and management of her postoperative hypoxia.

Miss Webb’s chest radiograph

Results of laboratory analysis of pericardial fluid

Test	Result
Protein	53 g/l
Lactose dehydrogenase	383 IU/l
White cells	19×10 ⁶ /l
Lymphocytes	50%
Polymorphs	50%
Red blood cells	2.74×10 ⁹ /l
Bacterial growth	Negative
Acid-fast bacilli	Negative

Questions

- 1 What further investigations would you do?
- 2 What is the likely diagnosis?
- 3 How would you treat this patient?

Please respond through bmj.com, remembering that Miss Webb is a real patient and that she and her carers will read your response

We suspected a pulmonary embolism but her V/Q scan showed no abnormality. She then had echocardiography to investigate unexplained hypoxia and possible cardiomegaly seen in the chest radiograph. This showed a large pericardial effusion with a normal cardiac anatomy and function. A pericardial drain was inserted, and 1100 ml of straw coloured fluid was drained. The table gives the results of laboratory analysis of the aspirate. She made good progress immediately after the drainage of pericardial fluid and her oxygen saturation returned to normal. She was transferred to a medical ward after three days in the intensive therapy unit. One week later, repeat echocardiography showed only trivial pericardial effusion. She was discharged from hospital with a diagnosis of pericardial effusion of unknown cause.

One month later, she was readmitted to the hospital with gradually worsening shortness of breath, cyanosis, and one episode of loss of consciousness lasting for a few seconds. Clinically she looked very unwell. The figure shows her chest radiograph. Echocardiography showed the recurrence of a large pericardial effusion.

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