warfarinisation, as early as day 1, peaking at day 3, and rarely occurring beyond day 10. In contrast, warfarin therapy is often long established when it is associated with calciphylaxis.

Treatment options for calciphylaxis include management of concurrent infection, treatment of hyperparathyroidism and removal of sensitising factors. There have also been reported cases of successful recovery with intravenous sodium thiosulphate, which is a potent reducing agent and is emerging as an important experimental treatment option. Successful treatment with hyperbaric oxygen has also been reported. Due to the uncertainty of management options however a multi-intervention approach is often adopted.[7,8]

Given the high mortality associated with NUC (reported to be >50%), it is possible that many cases are undiagnosed before death, or misdiagnosed, attributed instead to non-healing leg ulcers of other aetiology. This highlights the importance of raising awareness of the condition, especially given that novel treatment strategies exist for the disease. We encourage general physicians to consider NUC as a differential diagnosis in patients with an established cause or known risk factors. ■

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Image of the month: The Mount Fuji sign

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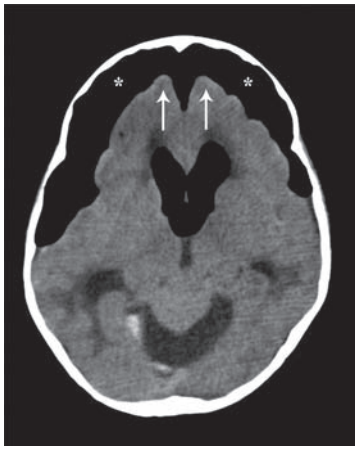

Fig 1. Axial unenhanced computed tomography images of the brain demonstrates bilateral subdural hypoattenuating areas (*) causing compression of the frontal lobes. Note the widening of the inter-hemispheric space between the tips of the frontal lobes (white arrows) forming the characteristic silhouette of Mount Fuji.

A 6 year-old-girl developed decreased responsiveness 12 hours after surgical resection of a pilocytic astrocytoma by posterior fossa craniotomy. Computed tomography of the brain demonstrated the 'Mount Fuji sign' (Fig 1). This sign refers to hypoattenuating subdural air that causes compression and separation of bilateral frontal lobes suggestive of underlying tension pneumocephalus and warrants emergent neurosurgical reference.[1] ■

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