Images in...

Two different intracranial haemorrhages and one cerebral infarction: what are the odds?

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DESCRIPTION

A 60-year-old epileptic woman was brought to A&E obtunded. Before 1 h, she fell onto the ground and hit her head after developing a seizure. Her Glasgow Coma Scale (GCS) was 6/15. An urgent CT brain scan was done (figure 1) and the patient was immediately transferred to the intensive care unit. The family declined neurosurgical intervention. On day 4, she became comatose with a GCS...
Abe et al\(^1\) found that most of the ischaemic brain damage noted in patients with acute subdural haematomas (SDHs) was an aftermath of arterial compression secondary to brain shift and herniation syndromes rather than the direct effect of the haematoma itself upon the underlying brain. Furthermore, they suggested that this ischaemic brain damage adversely affects the morbidity and outcome, and the difficulty in preventing ischaemic damage in cases with marked brain shift leads to poor outcome in patients with acute SDHs. According to Wani et al\(^2\), these infarctions are ‘commonly seen’ in acute SDHs. In figure 2, we can notice that the SDH has become denser, signifying the occurrence of a recurrent bleed.

Learning points

▸ Head trauma can result in more than one type of intracranial haemorrhage.
▸ The asymmetric increment in the intracranial pressure as well as the midline shift induced by acute subdural haematomas can result in secondary compression on major brain arteries with subsequent ischaemic infarctions. The latter vascular event challenges the management and deteriorates the prognosis.
▸ This type of arterial occlusion is common in acute subdural haematomas. The treating medical/surgical team should vigilantly search for this complication when patients develop new focal or lateralising signs or a rapid downhill course ensues.

Competing interests None.

Patient consent Obtained.

REFERENCES