

Emergency Management of Subdural Hematoma

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ABSTRACT

Background: subdural hematoma is extra-cerebral accumulation of blood between the dura matter and the subarachnoid layer. It is almost always caused by trauma or due to blood thinning therapies and occurs due to rupture of bridging veins. Acute subdural hematoma is an emergency situation and requires prompt diagnosis using CT most of the time and management requires surgery as well as reversal of anticoagulants.

Aim of the work: In this review, we aimed to study the etiology of subdural hematoma, explore how to diagnoses and manage it in the emergency department. **Methodology:** we conducted this review using a comprehensive search of MEDLINE, PubMed and EMBASE, from January 1985 to February 2017.

Results: surgery is most important intervention in managing subdural hematomas. **Conclusion:** subdural hematoma is an important clinical presentation that needs proper and prompt surgical management and treatment. Treatment should be as less invasive as possible, with higher efficacy and lower recurrence rates. No-surgical approaches are still being studied with no proven efficacy for them until now.

Keywords: subdural hematoma, diagnosis in emergency room for subdural hematoma, CT vs. MRI, management of subdural hematoma.

INTRODUCTION

Extra-cerebral accumulation of blood (whether liquid or clotted) between the dura matter and the subarachnoid layer is called subdural hematoma. This hematoma does not cause expansion of the subarachnoid area. The cause of this hematoma is almost always trauma. Hematoma will cause an accumulation that will lead to compression of the brain and focal neurological manifestations. Moreover, it causes an increase in intracranial pressure (with subsequent sequelae) and can affect consciousness ^[1]. The classification of subdural hematomas depends mainly on the time between the causing trauma and the onset of clinical signs of symptoms. Subdural hematomas can be classified as the following: ^[2]

- Acute subdural hematoma: onset of clinical signs and symptoms is within three days following trauma.
- Subacute subdural hematoma: onset of clinical signs and symptoms is within 4-21 days following trauma.
- Chronic subdural hematoma: onset of clinical signs and symptoms is after more than 21 days following trauma.

METHODOLOGY

• Data Sources and Search terms

We conducted this review using a comprehensive search of MEDLINE, PubMed and EMBASE, from

January 1985 to February 2017. The following search terms were used: subdural hematoma, emergency management of subdural hematoma, CT vs. MRI in diagnosis of subdural hematoma, treatment of subdural hematoma

• Data Extraction

Two reviewers have independently reviewed the studies, abstracted data, and disagreements were resolved by consensus. Studies were evaluated for quality and a review protocol was followed throughout.

The study was done after approval of ethical board of Majmaah university.

Etiology

Subdural hematomas constitute up to 3% of cases presenting to neurosurgery clinics and are most likely due to preceding trauma. Usually, trauma causing subdural hematoma is minor, anteroposterior and is associated with emissary veins rupture. The long term use of antiplatelets and anticoagulants has been linked to the occurrence of subdural hematomas and had been shown to affect manifestations and complications, especially in chronic hematomas. Moreover, a study had found that anti-platelets and anticoagulants may be responsible for the occurrence of spontaneous (also known as non-traumatic) subdural hematoma. However, the use of these drugs is still considered a predisposing factor rather than a causing etiology ^[1].

DIAGNOSIS

Signs and Symptoms

Chronic subdural hematoma can be quite challenging to diagnose, especially due to its high incidence among elderly, with the vague presentation of only decreased physical activity. Additionally, the causing trauma may be forgotten or neglected, causing many cases of misdiagnosis. This makes a thorough history that takes even minor trauma into consideration essential. This would not be only the responsibility of the patient, but also family members. Other than trauma, the presence of focal signs indicating brain damage (mainly motor), significantly decreased physical activity and the fluctuation of symptoms, all must raise the suspicion of diagnosis of subdural hematoma. Other non-specific findings included headache, elevated intracranial pressure with its associated signs and/or drowsiness. The nature of signs and symptoms may help in the localization of the injury. However, confirmation is still needed^[3].

Investigations

CT vs. MRI

CT and MRI are the main imaging modalities used to diagnose a subdural hematoma, with each one having its advantages and disadvantages. CT imaging is more rapid, more feasible and less expensive than MRI. It can help reach a diagnosis within a relatively short time and aid for proper early management. On the other hand, MRI provides valid more accurate results than CT and can show the injured bones more clearly. It is also effective when diffuse axonal injuries are suspected, which cannot be detected in CT or other modalities. The term diffused axonal injuries describes degeneration of the Wallerian axons causing axonal disintegration. Diffused axonal injuries occur mainly in the white matter of the parasagittal cortex, the pontomesencephalic junction and the corpus callosum^[4].

In addition to this, MRI can provide clearer imaging with exact location and dimensions of the hematoma. It can also show the relation of the hematoma with other near structures and the presence or absence of a mass effect by the hematoma. MRI also provides a more useful method in cases of bilateral and/or isodense hematomas. This more accurate and clear information provided by MRI allows the possibility of a better more effective surgical approach to correct the defect^[5].

TREATMENT

Surgery

Surgery is most important intervention in managing subdural hematomas. Surgical techniques have developed a lot in the recent years causing better outcomes. Common surgical techniques in the treatment of subdural hematoma included:^[6-8]

- Single burr hole technique (also known as minimal craniotomy), which uses a small hole which is smaller than 3 cm, with a closed vacuum drainage system. This technique has a variation where sodium chloride solution (physiologic serum) is used for irrigation.
- Twist drill trephination technique that also uses a closed system for drainage. This technique has a variant called the two-minimal craniotomy technique.
- Craniotomy with a diameter of more than 3 cm, which is used a vacuum closed system for drainage. This technique is mainly used in old cases characterized by the presence of a chronic septated hematoma.

Patients with Anticoagulant Therapy

Patients with anticoagulants therapy presenting with chronic subdural hematoma should be treated separately. This population is of special importance due to the continuous increase in chronic oral anticoagulants use. A recent research found that the risk of developing subdural hematoma can be up to 40 times more in individuals on anticoagulants than individuals who are not. Another Swiss study reported that up to 40% of patients with chronic subdural hematoma are on a daily anticoagulants regimen^[9].

Anticoagulant treatment does not only raise the risk of developing a subdural hematoma, but also makes its treatment more complicated, due to effects of coagulopathy. Therefore, when patients with anticoagulants therapy present with a chronic subdural hematoma the following must be considered: their anticoagulants regimen must be adjusted to prevent the recurrence of hematoma and to make surgery more feasible. Even patients with specific indications if anticoagulants (like severe cardiac pathology) should be treated in this case^[8].

Patients with antiplatelet therapy are also considered at higher risk of developing hematoma and progressing to complications related to it, although their risk is still lower than patients on anticoagulants. When these patients present with a

chronic subdural hematoma, the first step is to stop the anti-platelets therapy allowing for a proper neurosurgical management. After proper management is performed, the reintroduction of drugs can be considered with careful considerations [9].

Reversal of Coagulopathy

The reversal of coagulopathy can be essential in some cases but also has its risks. Any patient with a subdural hematoma carries a risk of developing an intracerebral hemorrhage, or a huge hematoma expansion when coagulopathy is significant. In subdural hematoma cases where acute exacerbation occurs on top of a chronic case, there is an excessive activation of coagulation and fibrinolysis, making clot formation unlikely, and thus the expansion very likely. Reversing anticoagulation must be considered regarding advantages and disadvantages of it. Data regarding this issue is still very limited in the literature. Moreover, the risk of bleeding may be high in some cases. When considering reversal, the INR target is usually 1.2-1.5. In fact, some researchers suggest that reversing anticoagulation rapidly can significantly improve the prognosis of intracranial hemorrhage and lead to lower mortality rates. Anticoagulation reversal can be achieved using fresh frozen plasma, vitamin K, recombinant activated factor VII (rFVIIa), and prothrombin complex concentrates [8].

Reversal of Antiplatelet Treatment

Varying data showed the effect of antiplatelets therapy on the expansion of hematoma and the occurrence of further complications. However, some suggest that being on these drugs can increase the risk of growth and expansion. Patients with these drugs who present with manifestations of hematoma are recommended to receive rFVIIa, platelets and desmopressin, which on the other hand are not used for the reversal of coagulopathy. Desmopressin has actually shown benefits of anti-platelets reversal when was infused for 20 minutes before neurosurgery [10].

CONCLUSION

Subdural hematoma is an important clinical presentation that needs proper surgical management and treatment. Many techniques for surgery are

present, however, relapse rates are still relatively high and studies on surgical techniques efficacy are not conclusive. Generally, any treatment should be as less invasive as possible, with higher efficacy and lower recurrence rates. Non-surgical approaches are still being studied with no proven efficacy for them until now.

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