

## Non-surgical management of intracranial subdural hematoma complicating spinal anesthesia

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### Summary

**We report the case of a 29 year-old woman who presented a symptomatic intracranial subdural hematoma developing shortly after spinal anesthesia.**

**The patient was fully conscious at clinical onset, and thus we treated her conservatively with an epidural autologous blood patch and close neurological observation. Given the clinical improvement the possibility of surgery was discauded in agreement with the neurosurgical team.**

**Most cases of subdural hematoma appearing after spinal anesthesia are treated with surgery. In the present case the subdural hemorrhage was detected at our hospital 20 days after the anesthetic procedure, and given the excellent state of consciousness, we choosed a conservative management.**

KEY WORDS: Complications. Epidural blood patch. Magnetic resonance imaging. Postdural puncture headache. Subdural hematoma.

**Manejo no quirúrgico de hematoma subdural intracranial tras anestesia espinal complicada**

### Resumen

**El hematoma subdural (SDH) es una complicación evolutiva rara, documentada y de riesgo vital en los cuadros de cefalea post punción subdural (PDPH). Presentamos un caso de esta rara complicación resuelto con un parche de sangre autóloga epidural y tratamiento conservador, sin precisar evacuación quirúrgica.**

PALABRAS CLAVE: Resonancia magnética. Cefalea postural. Hematoma subdural. Complicación. Parche epidural hemático.

### Introduction

Subdural hematoma (SDH) is a rare but, documented and life-threatening complication after dural punctures often manifested by post-dural puncture headache (PDPH)<sup>1,6</sup>. We report a case of this uncommon complication resolved through autologous epidural blood patch (EBP) and conservative treatment without the need for surgical drainage.

### Case description

A 29-year old woman was admitted to our neurosurgery department presenting with expressive dysphasia and complaining of headache and numbness in her upper right limb and face. She had undergone an emergency cesarean section for acute fetal distress while under subarachnoid anesthesia in another hospital 20 days prior to admittance in our hospital. The patient's pregnancy had evolved normally, having received the routine prenatal care.

The patient had no history of a neurological or blood disease, migraine, cancer or infection. No antecedent of head injury before or after the spinal anesthesia was reported. She denied the intake of cronic treatment or using tobacco, alcohol, or street drugs. Her history revealed an allergy to pyrazolone.

While undergoing spinal anesthesia the patient appeared anxious, and the anesthesiologist encountered technical difficulties with needle insertion. On a second attempt a subarachnoid puncture at L2-L3 level was achieved with a 26-gauge needle, pencil-point (Sims Portex Limited, Hythe, Kent, UK). The anesthetic level was appropriate with hyperbaric bupivacaine 0.5% (10 mg) plus 15 µg of fentanyl. Surgery elapsed uneventfully.

Twelve hours after the procedure, the patient complained of an intense generalized headache that got worse upon sitting upright. No fever or signs of meningeal irritation

*Abbreviations.* CSF: cerebrospinal fluid. EBP: epidural blood patch. PDPH: post dural puncture headache. SDH: subdural hematoma

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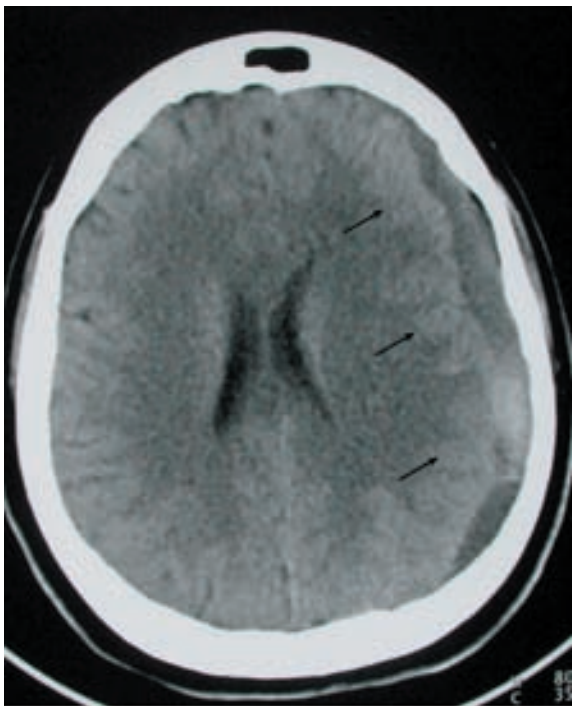


Figure 1. Cranial computed tomography scan showing frontal parietal subdural hematoma (subacute or chronic) with inner hyperdense area of recent bleeding. Very mild mass effect on the midline, ventricles, and adjacent cortical sulci. (black arrows).

were noted. A diagnosis of PDPH was made and accordingly, she was given analgesics, oral hydration, and bed-rest. By the fourth day, the patient showed a slight improvement and was discharged home.

Twenty days later the patient was brought to the emergency department of our hospital complaining of severe headaches that was not relieved by lying down, and numbness in her upper right limb and face. On examination, the patient was afebrile, alert and orientated but showed expressive dysphasia. No papilloedema was detected upon eye examination.

Coagulation tests and complete blood count, including platelets and white blood, were within normal range.

A plain cranial computed tomography (CT) and an emergency gadolinium-enhanced cranial and lumbar MRI revealed an extensive left frontal - temporo- parietal SDH with scattered areas of acute and subacute supratentorial hemorrhage and lumbar meningeal thickening without evidence of cerebrospinal fluid (CSF) fistula (figures 1,2 and 3). Upon consultation with neurosurgery and given the good neurological health status of the patient, it was decided not to surgically evacuate the collection but rather maintain a “wait and watch” approach, initiate medical treatment, and perform a lumbar autologous EPB. Blood

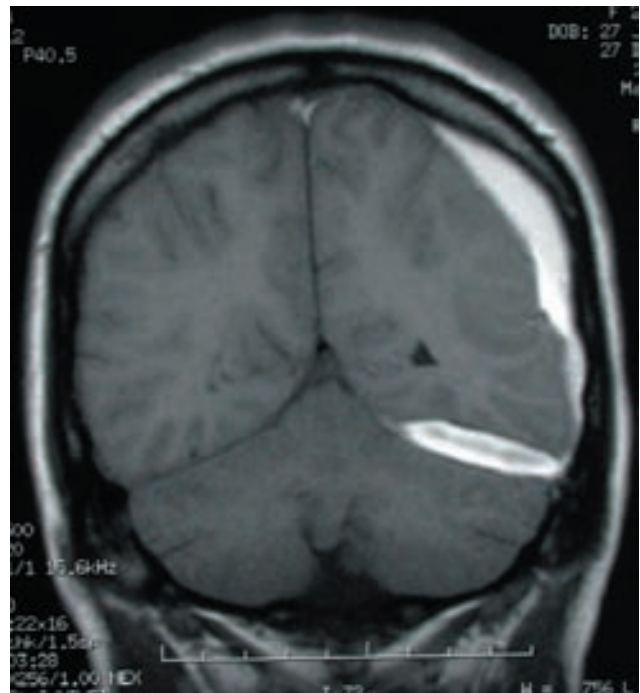


Figure 2. Coronal T1-weighted MRI: hyperintense hematoma in the subdural wall and the tentorium cerebelli (subacute or with evident chronicity) with mass effect on cortical sulci.

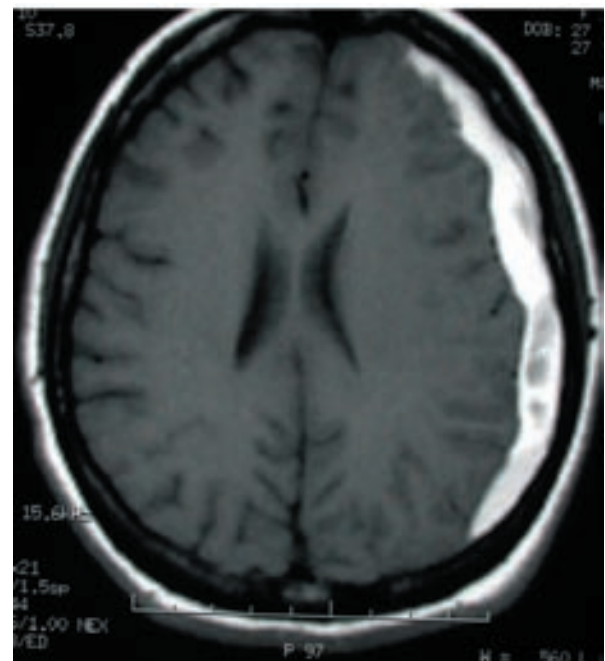


Figure 3. Axial T1-weighted MRI of hyperintense crescent-shaped hemorrhage with iso-intense areas due to subacute hematoma and inner areas of acute bleeding. Very mild mass effect on the midline, ventricles, and cortical sulci is visible.

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