Rare disease

'Idiopathic' chronic bilateral subdural haematoma – a separate entity or a missed cause?

Syed Viqar Ahmed, Stephen Bonny, Sumit Chandra

Acute Medicine Department, Stepping Hill Hospital, Stockport, Manchester, UK

Correspondence to Dr Syed Viqar Ahmed, syedviqarahmed@hotmail.com

Summary

A 65-year-old female was admitted with an 8-week history of gradual onset headache. The headache was worse in the morning and on bending forwards. This was associated with 1 week history of vomiting and 1 day history of difficulty in walking. Medical history was unremarkable apart from treated hypothyroidism. There was no history of trauma. Observations and physical examination were entirely normal. Routine blood tests including the ESR and clotting profile were normal. Given the history had red flags for headache, a CT scan was ordered and this showed bilateral subdural haematomas. The patient was referred to the regional neurosurgical centre where the haematomas were evacuated with good recovery. A follow-up MRI brain and spine did not show any source of bleeding.

BACKGROUND

The case highlights the importance of using red flags in a headache history to identify a rare secondary cause promptly.

Chronic bilateral subdural haematoma tend to occur in patients older than 75 years.¹ English literature search failed to identify any cases of 'Idiopathic' chronic bilateral subdural haematomas in the absence of recognised precipitating or coexisting conditions, as in this case. It is unlikely

to be a forgotten trauma in a 65-year fit female in full time active job.

CASE PRESENTATION

A 65-year-old fit female, with medical history of hypothyroidism, was referred by general practitioner for assessment of a generalised, constant 'tight band like' headache over an 8 week period. The headache started gradually and had become more severe over the previous 10 days. It was

Figure 1 CT brain scan showing bilateral subdural haematomas.

Figure 2 MRI of brain showing burr hole sites.

worse in the morning and aggravated on bending forwards. One week prior to admission, she developed nausea and vomiting followed by difficulty in walking. She categorically denied any minor or major trauma in the past. There was no history of renal, liver, cerebrovascular or ischaemic heart disease, diabetes, hypertension and epilepsy. She was not on any anticoagulant or antiplatelet treatment. Her weekly alcohol intake was limited to 20 units which she stopped 1 month prior to admission. She stopped smoking 15 years ago. There was no history of bleeding diathesis or intracranial haemorrhage in the family.

Her systemic examination, including a detailed neurological examination was normal apart from mild gait ataxia. Laboratory profile, including clotting screen was normal.

A CT brain scan confirmed bilateral subdural haematomas which were subsequently evacuated through bilateral burr hole surgery and she made a complete recovery.

INVESTIGATIONS

The CT brain scan showed evidence of bilateral chronic subdural haematoma of approximately similar size at 11 mm in width and extending from the level of the lateral ventricles to the vertex (figure 1).

There was no apparent midline shift although there was generalised sulcal effacement and downward compression, obliterating the basal cisterns and the prepontine cistern. On bony algorithm, sinuses and mastoid air cells were clear. No fracture was identified.

MRI brain and whole spine did not show any source of bleeding leading to bilateral subdural haematomas.

TREATMENT

The definitive treatment is evacuation of the bilateral haematomas via a single incision bilaterally with burr holes (figure 2).

OUTCOME AND FOLLOW-UP

The patient made a slow but complete recovery following haematoma evacuation and was discharged back to the care of her general practitioner.

DISCUSSION

Chronic subdural haematomas are mostly seen in patients over 75 years following trauma (commonest cause), bleeding diathesis or coagulation abnormalities. Other precipitating factors include epilepsy, haemodialysis and alcohol intake. A number of coexisting vascular illnesses

are associated including hypertension, diabetes, ischaemic heart disease, cerebrovascular disease, renal disease, liver disease, chronic alcohol excess and smoking.¹ Chronic bilateral subdural haematoma constitutes 16% to 20% of chronic subdural haematomas. Prompt investigation and referral to the specialist neurosurgical centre lead to an early surgery with an excellent outcome.

It is extremely rare for bilateral spontaneous subdural haematomas to occur although they have been described in the literature.^{2–4} The main cause of the referenced bilateral subdurals without trauma or vascular pathology was due to spontaneous intracranial hypotension.^{3 4} Our case report did not have a clear cause; however, intracranial hypotension was noted on the MRI scan postoperatively.

This report illustrates a case of bilateral chronic subdural haematoma of unknown aetiology in a relatively younger female in the absence of trauma or any other precipitating or coexisting illnesses.

It may be a case of missed cause or a separate disease entity.

Learning points

- ▶ Must not ignore red flags when taking a history for headache.⁵
- ▶ A normal neurological examination does not rule out a secondary cause of headache.
- ▶ Subdural haematomas can occur in the absence of head injury.
- ▶ Prompt recognition with surgical intervention will lead to a better outcome for the patient.

Competing interests None.

Patient consent Obtained.

REFERENCES

1. **Tai-Hsin T**, Ann-Shung L, Shih-Lin H, *et al.* A comparative study of the patients with bilateral or unilateral chronic subdural hematoma: precipitating factors and postoperative outcomes. *The J Trauma* 2010;**68**:571–5.
2. **Buruma OJ**, Sande JJ. Bilateral acute spontaneous subdural hematoma. A case report. *Clin Neurol Neurosurg* 1976;**79**:211–4.
3. **Souirti Z**, Benzagmout M, Belahsen F, *et al.* Spontaneous bilateral subacute subdural hematoma revealing intracranial hypotension. *Neurosciences (Riyadh)* 2009;**14**:384–5.
4. **Srimanee D**, Pasutharnchat N, Phanthumchinda K. Bilateral subdural hematomas and hearing disturbances caused by spontaneous intracranial hypotension. *J Med Assoc Thai* 2009;**92**:1538–43.
5. Scottish Intercollegiate Guidelines Network. Diagnosis and management of headache in adults: a national clinical guideline. November 2008 <http://www.sign.ac.uk/pdf/qrg107.pdf> (accessed on 20 March 2011).

This pdf has been created automatically from the final edited text and images.

Copyright 2011 BMJ Publishing Group. All rights reserved. For permission to reuse any of this content visit <http://group.bmj.com/group/rights-licensing/permissions>.

BMJ Case Report Fellows may re-use this article for personal use and teaching without any further permission.

Please cite this article as follows (you will need to access the article online to obtain the date of publication).

Ahmed SV, Bonny S, Chandra S. 'Idiopathic' chronic bilateral subdural haematoma – a separate entity or a missed cause?. *BMJ Case Reports* 2011;10.1136/bcr.09.2011.4771, Published XXX

Become a Fellow of BMJ Case Reports today and you can:

- ▶ Submit as many cases as you like
- ▶ Enjoy fast sympathetic peer review and rapid publication of accepted articles
- ▶ Access all the published articles
- ▶ Re-use any of the published material for personal use and teaching without further permission

For information on Institutional Fellowships contact consortiasales@bmjgroup.com

Visit casereports.bmj.com for more articles like this and to become a Fellow