IMAGE PRESENTATION

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Giant Traumatic Parafalcine Subdural Hematoma

Dev Travmatik Parafalsin Subdural Hematom

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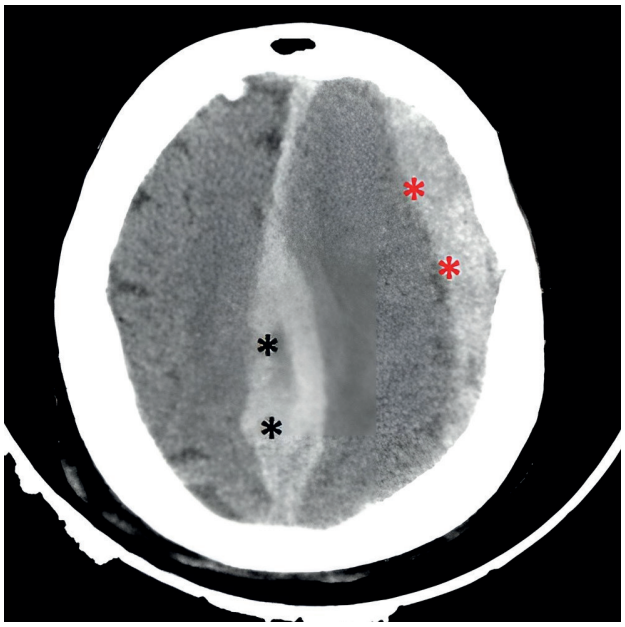

Figure 1: Preoperative computed tomography images of the patient. Acute subdural hematoma surrounding the cerebral convexity on the left, measuring 19 mm in its thickest part (red asterixis). Parafalcine subdural hematoma, measuring 19 mm in its thickest part (black asterixis).

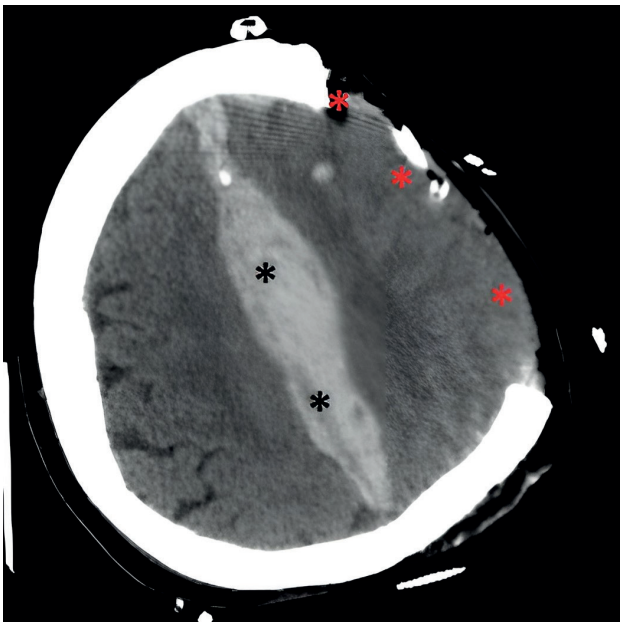

Figure 2: Postoperative computed tomography images of the patient. Craniectomy defect (red asterixis). Persisted parafalcine subdural hemorrhage (black asterixis).

A 77-year-old female patient was admitted to our clinic head injury from falling downstairs. It was learned from the anamnesis taken from the relatives that she had heart surgery 3 months ago and was using clopidogrel and metoprolol. On admission, blood pressure was 176/85 mmHg, and pulse rate was 75 /minute. On physical examination, her Glasgow Coma Score was 9 (eye 3, motor 3, verbal 3). There was subcutaneous emphysema, especially on the left side of the scalp. The patient had anisocoria, the left pupil diameter was larger than the right. Hematological, biochemical and coagulation parameters of the patient were within normal limits.

Computed tomography showed an acute subdural hematoma surrounding the cerebral convexity on the left, measuring 19 mm in its thickest part, and measuring 19 mm in the parafalcine region. The cerebral parenchyma was compressed and a slight shift to the right in the midline was observed (Figure 1). Emergency decompressive craniectomy was performed. In the postoperative computerized tomography, the compression of the parenchyma was decreased, and the parafalcine subdural hemorrhage persisted (Figure 2). The patient admitted to the intensive care unit and died on the 3rd day of admission to the intensive care unit.

Parafalcine subdural hemorrhage was first described by Arring and Evans in 1940 as an atypical localization (1). On the other hand, it has become more recognized due to the widespread availability of computed tomography since that day (2). Hemorrhages in the parafalcine region constitute 9-15% of all blunt trauma-induced intracranial hemorrhages (3). Although small amounts of parafalcine hemorrhages are benign, mortality is high in hemorrhages with high volume bleeding and high convexity (2,3).

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Ethic: Informed consent was obtained from the patient.
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REFERENCES

1. Aring CD, Evans JP. Aberrant Location of Subdural Hematoma. Arch NeurPsych. 1940;44(6):1296-306.
2. Cragun BN, Noorbakhsh MR, Hite Philp F, Suydam ER, Ditillo MF, Philp AS, Murdock AD. Traumatic Parafalcine Subdural Hematoma: A Clinically Benign Finding. J Surg Res. 2020;249:99-103.
3. Howard BM, Rindler RS, Holland CM, Pradilla G, Ahmad FU. Management and Outcomes of Isolated Tentorial and Parafalcine "Smear" Subdural Hematomas at a Level-1 Trauma Center: Necessity of High Acuity Care. J Neurotrauma. 2017;34(1):128-136.