Bilateral hypodense chronic subdural hematoma

- Factors influencing wait-and-watch management in mild primary chronic subdural hematoma: a retrospective case-control study
- Subdural false twins: concomitant appearance of subdural haematoma and spontaneous subdural empyema
- Bedside Percutaneous Twist Drill Craniostomy of Chronic Subdural Hematoma-A Single-Center Study
- External validation and modification of the Oslo grading system for prediction of postoperative recurrence of chronic subdural hematoma
- Comparative Study of Single Burr-Hole Craniostomy versus Twist-Drill Craniostomy in Patients with Chronic Subdural Hematoma
- Risk Factors for Contralateral Hematoma Progression after Unilateral Evacuation of Bilateral Chronic Subdural Hematomas
- Multiple Densities of the Chronic Subdural Hematoma in CT Scans
- What determines the laterality of the chronic subdural hematoma?

Case reports

A 55-year-old man was taken to the emergency department due to right arm weakness for the past 3 days and fever (39.5°C). There was no impaired consciousness, no history of trauma and meningeal signs were absent on physical examination. Blood analysis and inflammatory markers were not evocative of a systemic infection. A cranial CT scan was requested, revealing hypodense bilateral hemispheric subdural collections, suggestive of chronic subdural haematomas. He was submitted to surgical drainage by burr holes, which confirmed the chronic subdural collection on the left side. Unexpectedly, after dural opening on the right side, a subdural purulent collection was found, which was later confirmed as an empyema due to Escherichia coli infection. A second surgical drainage was performed by craniotomy due to recurrence of the right subdural collection. Spontaneously appearing subdural empyemas due to E. coli are extremely rare and their treatment is not always straightforward. The reported case is an example of an apparently straightforward and frequent pathology that turned out to be a challenging case, requiring a multidisciplinary approach [1)].

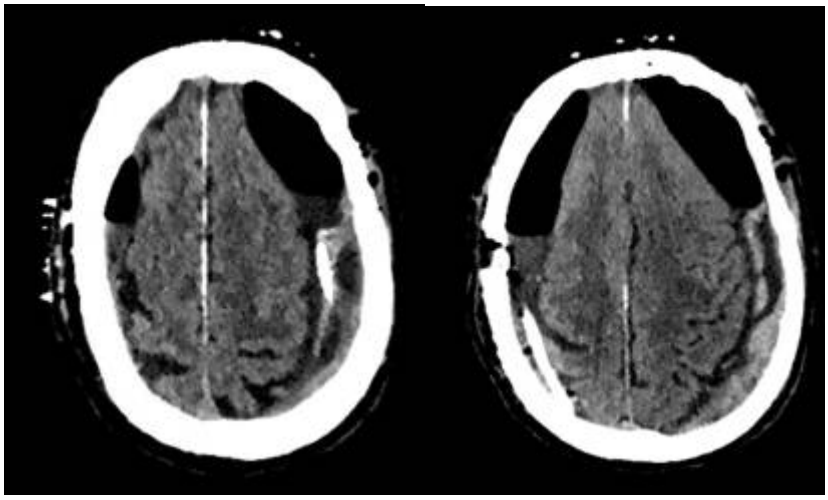
Case reports from the HGUA

The patient, an 80-year-old man, presents with a history of disorientation over the past week. His medical history includes Chronic Kidney Disease at Stage 3, spherocytosis, thrombocytosis, and Benign Prostatic Hyperplasia. The current medications include Amlodipine, Losartan, and Dutasteride/tamsulosin. A history of splenectomy has been noted.

The CT scan showed a Bilateral hypodense chronic subdural hematoma

A bilateral Burr hole trephination for chronic subdural hematoma evacuation was performed.

The postoperative CT scan



Renal Monitoring: Regular monitoring of renal function, considering the stage of CKD, to ensure appropriate management.

Hematological Follow-up: Ongoing assessment of thrombocytosis with adjustments to treatment if necessary.

Urological Consultation: A urological evaluation to assess the impact of BPH on the patient's overall health and cognitive function.

Review of Current Medication: Evaluation of the current medication regimen, considering potential interactions or adjustments based on clinical response.

Nephrology Follow-up: Regular monitoring of renal function and adjustment of CKD management.

Hematology Review: Periodic checks to assess thrombocytosis and modify treatment as needed.

Urological Follow-up: Continual assessment and management of Benign Prostatic Hyperplasia.

Conclusion: This case report highlights the need for a multidisciplinary approach in the evaluation and management of an elderly male patient presenting with disorientation. Close collaboration between neurology, nephrology, hematology, and urology will ensure comprehensive care, addressing both cognitive and underlying medical issues. Regular follow-ups are essential for monitoring progress and adjusting treatment plans accordingly

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Santos Cardoso R, Tavares S, Reis I, Alves JL. Subdural false twins: concomitant appearance of subdural haematoma and spontaneous subdural empyema. BMJ Case Rep. 2021 Jun 21;14(6):e240110. doi: 10.1136/bcr-2020-240110. PMID: 34155007; PMCID: PMC8217955.