A wide range of treatment modalities are employed in the treatment of chronic subdural haematoma (CSDH). A rational and evidence-based treatment strategy has the potential to optimise treatment for the individual patient and save resources. The aim of this study was to survey aspects of current practice in the UK and Ireland. A 1-page postal questionnaire addressing the treatment of primary (i.e. not recurrent) CSDH was sent to consultant SBNS members in March 2006. There were 112 responses from 215 questionnaires (52%). The preferred surgical technique was burr hole drainage (92%). Most surgeons prefer not to place a drain, with 27% never using one and 58% using drain only in one-quarter of cases or less. Only 11% of surgeons always place a drain, and only 30% place one in 75% of cases or more. The closed subdural-to-external drainage was most commonly used (91%) with closed subgaleal-to-external and subdural-to-peritoneal conduit used less often (3 and 4%, respectively). Only 5% of responders claimed to know the exact recurrence rate. The average perceived recurrence rate among the surgeons that never use drains and those who always use drains, was the same (both 11%). Most operations are performed by registrars (77%). Postoperative imaging is requested routinely by 32% of respondents and 57% of surgeons prescribe bed rest. Ninety four per cent surgeons employ conservative management in less than one-quarter of cases. Forty-two per cent of surgeons never prescribe steroids, 55% prescribe them to those managed conservatively. This survey demonstrates that there are diverse practices in the management of CSDH. This may be because of sufficiently persuasive evidence either does not exist or is not always taken into account. The current literature provides Class II and III evidence and there is a need for randomized studies to address the role of external drainage, steroids and postoperative bed rest [1)].

Medical records of patients diagnosed with idiopathic intracranial hypertension (IIH) between 2007 and 2014 in a general hospital in Northern Ireland were reviewed.

There were 45 patients with IIH, 44 women: 1 man. The mean age at presentation was 29.4 (SD 9.8) years and mean body mass index (BMI) 39.8 (SD 9.5) kg/ m2. All patients had neuroimaging, 44 (98%) had CT/MR venogram and 41 (91%) had visual perimetry. The crude incidence of IIH was 2.36 per 100,000 (95% CI 1.65-3.37). For women, the incidence was 4.65 per 100,000/year (95% CI 3.25-6.66). The prevalence was 14.3 per 100,000 overall (95% CI 9.72-20.9) but 28.1 per 100,000 in women (95% CI 19.2-41.2). Visual field defects were identified in 25 of 41 (61%); 4 patients (9%) required shunting procedures. At follow-up, the mean BMI decreased by 1.6 kg/m2 ($p = 0.024$).

The incidence of IIH in the northwest of Northern Ireland is among the highest ever reported and probably reflects the known increase in obesity [2)].

As part of a study into the management of major trauma, the early management of severe head injury in Northern Ireland was evaluated over a 12-month period. The injury severity score was used to define those patients considered to have severe head injury. There were 131 patients with severe head injury; 27 per cent were hypoxic and 18 per cent were hypotensive on admission to the primary hospital. Almost half had severe multiple injuries. Early endotracheal intubation was performed in 92 per cent of comatose patients, and adequate resuscitation (including laparotomy in some) was performed in 87 per cent of shocked patients transferred to the neurosurgical unit (NSU). Eighty patients were transferred to the NSU; 60 per cent were comatose, 68 per cent were intubated and ventilated, and 74 per cent were transferred by an anaesthetist. Two patients were in hypovolaemic shock after transfer and required laparotomy. Thirty-eight had evacuation of an acute intracranial haematoma; 26 of these would not have been classified as severe head injury by the Glasgow coma scale. The overall mortality rate was 38 per cent, and 24 per cent for those transferred to the NSU.

We conclude that the early management of head injury in Northern Ireland is good, but there are problems, including pre-hospital oxygenation and delays in transfer [3].

1)
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