

# Acute hypodense hemorrhage in an organized chronic subdural hematoma causing sudden neurological deterioration in a severely anemic patient

Amit Agarwal M Ch, Anand Kakani M Ch, Sanjot Ninave MBBS

Department of Neurosurgery, Datta Meghe Institute of Medical Sciences, Sawangi (Meghe), Wardha (India)

**Abstract:** A 60-year-old male presented with the history of generalized weakness of 7-day-duration. He had a seizure episode, followed by deterioration. CT showed acute-on-chronic subdural hematoma. Biochemical parameters revealed chronic renal failure. Although the clot was evacuated in emergency he continued to be vegetative.

**Keywords:** acute-on-chronic subdural hematoma; anemia; chronic subdural hematoma; hypodense subdural hematoma; organized chronic subdural hematoma

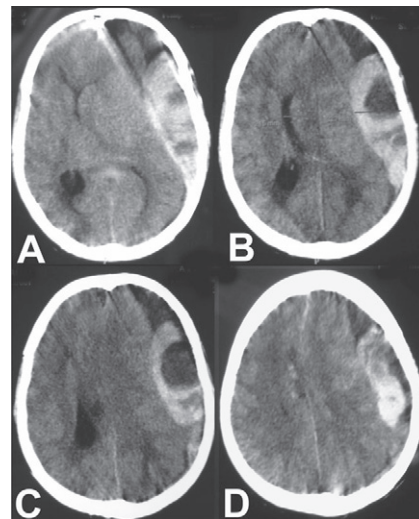
## INTRODUCTION

Organized chronic subdural hematomas, although uncommon lesions but are well described in literature<sup>1-9</sup>. We report an unusual case of acute hypodense hemorrhage in an organized chronic subdural hematoma causing sudden neurological deterioration in a severely anemic patient and discuss the relevant imaging and intra-operative findings.

## CASE REPORT

A 60-year-old male, a known hypertensive on irregular treatment, and habituated to alcohol, presented with generalized weakness of 7 days duration and breathing difficulty of one day duration. There was no history of fever, cough or hemoptysis. On examination the patient had been dehydrated and pale. Chest examination revealed crepitations in the middle zone of left lung. There was no hepato-splenomegaly. Following admission, he had an episode of seizure with neurological deterioration and decerebration. His Glasgow coma scale was E1V1M2, pupils were dilated and reacting sluggishly to light. An emergency CT scan showed heterogeneous concavo-convex lesion in the left fronto-temporo-parietal region with significant mass effect and midline shift (Fig 1). Further details from the relatives revealed that he had a fall in bathroom two months back. Hematological profile

showed severe microcytic hypochromic anemia (Hb- 4.8 gm%), total leukocyte count of 7000 cells/ mm<sup>3</sup>, with 79% polymorphs. His serum creatinine was 9.34 mg%, urea was 197mg%, with normal electrolytes. Total bilirubin was 0.7 mg%, SGPT was 44 IU/L and Alkaline Phosphatase was 411 IU/L. Other biochemical and coagulation parameters were within normal limits. The patient underwent left temporo-parietal craniotomy and evacuation of the organized subdural hematoma. Dural opening showed thick organized clot with gray, yellow-green paste like material, yellowish fluid and thick altered

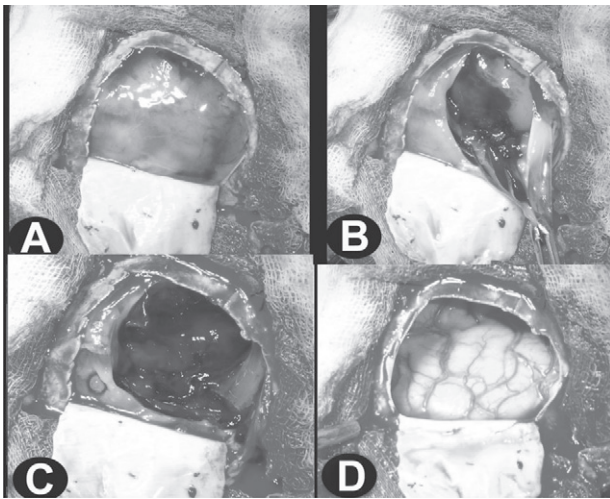


**Fig 1:** Computed tomography (CT) of the brain showing heterogeneous density of the lesion in the left fronto-temporo-parietal region with marked mass effect and midline shift (note the odd point that there was hypodense collection in the hyperdense collection contrary to classical hyperdense collection in the relative isodense or hypodense collection in cases of acute hemorrhage in chronic subdural hematoma)

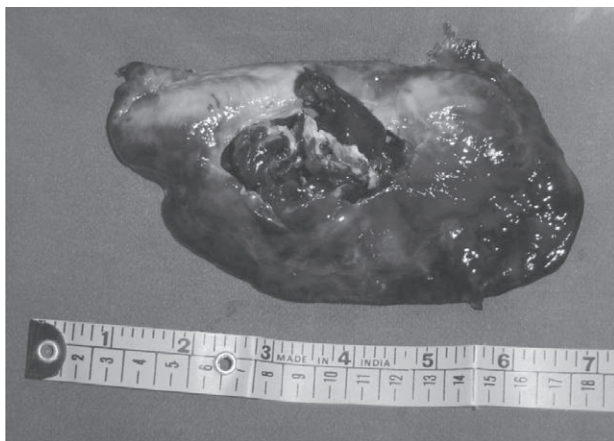
### Address for correspondence:

Dr Amit Agrawal  
Professor and Head, Department of Neurosurgery  
Datta Meghe Institute of Medical Sciences  
Sawangi (Meghe), Wardha- 442004, Maharashtra  
Phone: +91-7152-287701 Fax: +91-7152-287719  
Email: dramitagrawal@gmail.com, dramit\_in@yahoo.com

blood clot within it (Fig 2). The organized blood clot with evidence of fresh hemorrhage was retrieved from the subdural space (Fig 3). The organized part was corresponding with the hyperdense area on CT scan and fresh clotted blood was corresponding with the hypodense areas on CT scan. Yellowish fluid was corroborating with the hypodense collection all around the clot in CT scan. In post-operative period he did not have spontaneous respiration and was kept on elective venation. Neurologically his GCS remained E1V1M1, pupils remained dilated and fixed and extra-ocular movements were restricted. In spite of adequate hydration he had urine output of 200 ml in 24 hours, and died five days later.



**Fig 2:** Intra-operative images showing (A) thick yellowish mass after opening the dura, (B) the mass was firm and fleshy in consistency, (C) inside the mass there was collection of freshly clotted jelly like blood and (D) clear subdural space after removal of the clot



**Fig 3:** Gross specimen showing organized hematoma (15x10 cm in size) with evidence of recent hemorrhage

## DISCUSSION

Organized chronic subdural hematoma is composed of thick, fibrous, collagenous neomembrane and old thrombosis-like clot consisting of a large amount of fibrin. If it sufficient of age it may contain deposits of calcium, hemosiderin, and cholesterol in the neomembranes and trabeculae<sup>1,2,4</sup>. The CT appearance of the organized or partially calcified CSDH is not very specific and on CT scan appears as heterogeneous moderate high density<sup>2</sup>, sometimes mixed density with high density inner margins<sup>1</sup>, or it can appear as a homogeneous low density area<sup>6,8</sup>. The characteristics of these lesions on magnetic resonance (MRI) images have not yet been clarified but a combination of the CT scan and MRI will help in suspecting the preoperative diagnosis<sup>1,8</sup>. When we correlated the imaging and intra-operative findings it was found that hyperdense lesion on CT scan was the thick organized blood clot and contrary to our suspicion the hypodense collection was recently clotted blood in the specimen (Figs 1, 2 and 3). This hypodense appearance of the freshly clotted blood can be explained by the severe anemia in the patient. Systemic illness can complicate the CT appearance of acute hemorrhage in the cranial cavity<sup>10-13</sup> and subdural hematoma may appear as isodense to hypodense in patients with severe anemia<sup>11-16</sup>.

## MANAGEMENT

Although we suspected a diagnosis of acute-on-chronic subdural hematoma and performed the craniotomy, in cases where a pre-operative diagnosis of organized CSDH can be suspected a craniotomy is recommended<sup>1,2,6,8,9,17</sup>.

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