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Management of nontraumatic intracranial haemorrhage (subdural hematoma) in immune thrombocytopenia. Case report

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ABSTRACT

Intracranial haemorrhage is a devastating complication of immune thrombocytopenic purpura [1]. The occurrence of a spontaneous subdural hematoma in immune thrombocytopenia (ITP) is rare [2], affecting 1% or less of patients [3]. In ITP contrary to traumatic SDH the brain parenchyma is well preserved [3]. We present the case of a patient with immune thrombocytopenia, subdural haemorrhage and asymptomatic parietal parasagittal meningioma. Neurological parameters were closely monitored, including the level of consciousness, pupillary size, motor or sensorial deficit. He was managed successfully medically (platelet-rich plasma and steroids) and then surgically (craniotomy, subdural hematoma aspiration).

Keywords
hematoma, subdural, subarachnoid haemorrhage, idiopathic thrombocytopenic purpura

INTRODUCTION

We present tha case of a patient with imune thrombocytopenia intracerebral hemorhage and parietal parasagital meningioma.

CASE REPORT

We present the case of a patient who suferred a head trauma in uncclеared conditions. He acuse mild left hemiparesis (ASIA 4/5), intense headache VAS 8/10, vomiting and diziness, from 3 days. Few purpuric spots were noted on all the four members.

Medical datas revealed chronical ITP, without continous treatment Hemoglobine: 14,20 g/dl, TLC 4000/cm3. Coagulation tests were normal.

Clinical exam revealed mild hemiparesis (ASIA 4/5), osteotendinous reflexes diminished on the left side, Babinsky on the left side, purpuric lesions on all the four members. Glasgow scale 15.

CT scan of the head revealed hyperdensity in the subdural space in the temporo parieto occipital region on the right side, and in the subdural area in right posterior part of the sagital sinus,left parasagital meningioma.

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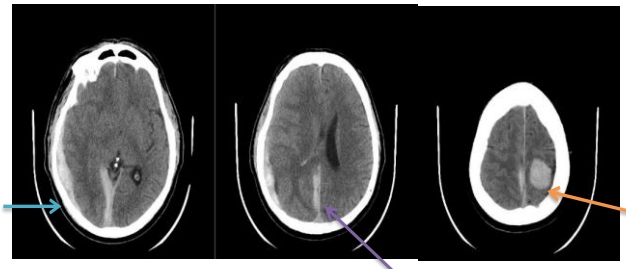
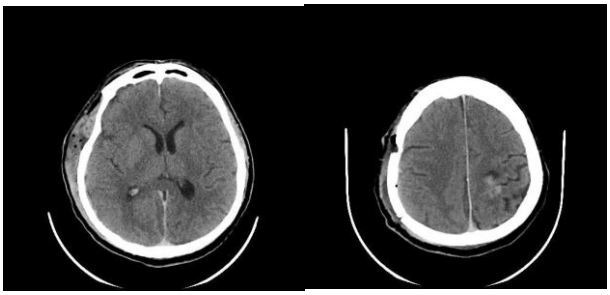


Figure 1. Temporoparietooccipital acute subdural hematoma (blue arrow). Acute subdural interemispheric (falx cerebri) (Pink arrow). Parietal parasagital meningioma (orange arrow).

The patient was treated with Dexametazone 40 mg/day and platelet transfusion.

After 4 days her platelet count rose to 130000/mm3 who allowed surgical intervention. Clinical status was stationary : intense headache (VAS 7/10), left hemiparesis (ASIA 4/5), vomiting 1-2/day, GCS 15.

The patient was operated (frontotemporo-parietoociipital craniotomy, complete evacuation of the subdural hematoma).



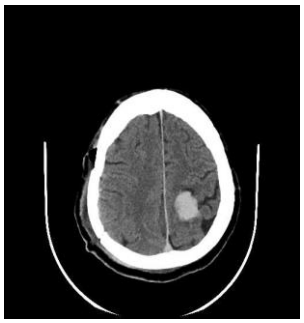


Figure 2. Complete evacuation of the subdural hematoma

Clinical postoperative evolution was very good with healing of hemiparesis, of headache, vomiting and diziness. Persisted only slight left pyramidal syndrome.

Discussion

Essential thrombocitopenia is revealed by constant diminution of the platelets without any cause. (Denis, Hayem, Frank.) ITP was first described by Werlhofin 1735[4] as an aquired disorder which leads to immune mediated destruction of platelets characterised by low platelet count and normal coagulation studies[4]. intracranial hemorrhage is a devastating complication of ITP[1,4]. The occurence of a spontaneous subdural hematoma in immune thrombocytopenia (ITP) is rare[2], affecting 1-2% or less of patients[3,4,5]. The clinical features are mainly headache, hemiparesis, signs of raised intracranial tension, altered consciousness[4]. Usually, subdural hematoma occurs, when are associatecd with ITP around the the top and side of the frontal and parietal lobes, in the posterior cranial fossa, near the falx cerebri and tentorium cerebelli[4]

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Conclusions

- Medical treatment enabled us to achieve an adequate hemostasis wich was esential to be able to perform surgery in proper time.
- Combination between medical treatment of imune thrombocitopenia and surgical treatment of acute subdural hematoma was mandatory for a good clininical and neurological evolution.

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