

A wolf in stroke's clothing: the hidden face of chronic subdural haematoma

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Dear Editor,

We write to highlight a recurring and pertinent issue in neurosurgical practice, one which carries with it a potential for grave consequences. Patients with chronic subdural haematoma (CSDH), a neurosurgical condition, often present with symptoms and signs that may mimic a cerebrovascular event (stroke).¹ Hence, they often present initially to the neurologists, who usually institute treatment protocols for stroke, which are mostly non-operative. The stroke protocols are usually continued until a neuroimaging is eventually done. This stroke-like presentation of CSDH often leads to a delay in neurosurgical intervention with an attendant worsening of outcome.

CSDH is one of the most common intracranial pathologies that neurosurgeons grapple with. It is mostly a disease of the elderly, and the incidence continues to rise globally due to an ageing population.² The common symptoms of CSDH, such as headache and focal neurologic deficits like hemiparesis or hemiplegia, are, however, non-specific and may be easily mistaken for a stroke. This diagnostic conundrum is further complicated by the fact that both conditions i.e. stroke and CSDH occur mostly in patients with similar demographics, that is, elderly patients with comorbidities like hypertension. These patients are usually on antihypertensive medications as well as antiplatelet medications which are a recognised risk factor for CSDH.

Furthermore, a history of head trauma which is often present in patients with CSDH and may help the clinician decipher between a stroke and CSDH is usually missed at initial presentation to the neurologists. This is due to a number of reasons. The trauma typically implicated in CSDH is usually very remote from the onset of symptoms and may have been forgotten by the patients and/or their relatives. Besides, the trauma is usually trivial and mostly considered inconsequential by patients and caregivers alike; and as such

the history of trauma is not usually readily volunteered.³ Hence, a cursory inquiry about a history of trauma often yields a negative response. All these are in addition to the innate bias of the neurologist or physician to make a medical diagnosis (stroke) rather than a surgical one (CSDH).

Cranial computerized tomographic (CT) scan is the first-line imaging modality in evaluating patients with suspected stroke in most facilities and will often confirm the diagnosis of a CSDH.⁴ However, missed cases have been reported even after neuroimaging. On the one hand, subdural haematomas in the subacute phase appear isodense on cranial CT scan, blend imperceptibly with the normal brain and may be easily missed; on the other hand, CSDH may be mistaken for an infarct from an ischaemic stroke as both may have similar appearances-hypodense, wedge-shaped and dura-based.

The foregoing often leads to a delay in the diagnosis and ultimately surgical treatment of CSDH. Thus, there is a more prolonged period of sustained elevation in intracranial pressure occasioned by the CSDH. This usually leads to neurological deterioration as well as a poorer outcome when surgery is eventually done and in some cases mortality. CSDHs are generally associated with good outcomes with complete resolution of neurologic symptoms and deficits when promptly addressed and are usually amenable to burr hole and haematoma drainage, a simple neurosurgical procedure.⁵

Therefore, there is a pertinent need for heightened awareness of CSDH as a stroke-mimic and impostor. We admonish clinicians and all first responders to always consider CSDH as a possible differential diagnosis in all patients presenting with stroke-like symptoms, especially those with risk factors such as advanced age, patients on antiplatelets or those with a history of trauma, even if trivial. We also recommend a very



low threshold for plain cranial CT scan or brain MRI in these patients. This will influence commencement of definitive treatment like thrombolytics for ischaemic stroke, facilitate timely diagnosis of CSDH and prompt referral for appropriate treatment, thus improving outcomes.

ETHICAL DECLARATIONS

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This letter was externally peer-reviewed.

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