

(CASE REPORT)



## Chronic subdural haematoma initially labeled as a psychiatric ailment: A case report

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### Abstract

Challenges of psychiatric disorder is more recognised as being relatively common in our environment and possibly not been diagnosed as frequently as it should be. The traditional belief system recognizes only the naked, or scantily dressed as obviously insane person who picks edible from waste dump and patrols the market square as a psychiatric patient. The causes of this mental disorder are myriad ranging from curses from our ancestors and parents, curses from person whom we had defrauded, ingestion of illicit drugs and alcoholic beverages and several others. Here we report an unusual situation of an adult native man who was living “alone” and who developed obvious signs of mental disorder. It is unheard of that a native man was living alone, no family members with him or him with them. What could have led to this unwholesome development?.

**Keywords:** Chronic Subdural Haematoma; Psychiatry; Curses; Living alone; Adult man.

### 1. Introduction

Chronic subdural haematoma (CSDH) is an encapsulated collection of old blood, with a “motor oil” appearance in the subdural space.<sup>1,2</sup> It can manifest after minor head trauma or from slow venous bleeding usually from bridging veins on the cerebral surface, although, other aetiology also exist.<sup>1,2</sup> It can occur anywhere along the neuroaxis and classically presents on the convexity of the cerebral hemisphere, unilaterally or bilaterally.<sup>1</sup> Its clinical presentation varies and can easily be miss diagnosed. This is a case report where with magnetic resonant imaging (MRI), a diagnosis was made and patient managed appropriately.

### 2. Case Report

Apparently, the kinsmen of an adult man of about 53yrs who was living all by himself in a self-contained apartment in a suburb of Lagos (Nigeria) called home to the man’s family that they should come and pick their ill-brother. The legend had it that the ill-man, who was a petty trader selling provision in a small shop by his residence was a known friendly figured around his neighbourhood. He was not known to be a troublesome person, minded his business closely and neither fought nor had any quarrel with anyone. He was not known to be deeply religious but occasionally went to a prayer house near his house on festive seasons only. He had no known family members living with him and rarely had visitors to his residence. He occasionally prepared his meals at home but mostly ate of local food vendors shops, just like many other people did in the neighbourhood. Nobody knew anything about his health condition, but report had it that, he appeared to be strong and healthy. Never smoked cigarette but occasionally joined other men in his neighbourhood to partake in drinking only soft drinks while others may take stronger beverages. He never discussed his family with anyone and few knew where he originated from.

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He later developed irrational talk, was confused and locked himself up for about one week. His neighbours had given him some native concoction to take but to no avail and gradually they noticed that he was weak on the right side of his body. At this stage, he was defaecating and passing urine on himself and his neighbours felt his family must take care of him. His brother at the village was called to come get him that his condition was critical.

He was therefore brought back to the village community in the confused, irrational state, incontinent of both urine and stool.

He was fed and cleaned and started on native medications but he was not improving and they decided to bring him to our facility for proper care.

At the first contact consultation, his brother who served as the informant knew that he was diagnosed as being hypertensive over four years prior to presentation at a missionary hospital near their village. But no information on whether he was taking his medication regularly. Informant was not aware of history of headache, vomiting, seizure. He was not a known seizure disorder, migraine nor psychiatric patient, no history of trauma to the head known by informant. He was not a known diabetic patient.

He had normal blood pressure on review and observed to be supported by relative since the right half of the body was weak.

The first contact clinicians diagnosed severe depression and right hemiplegia secondary to cardiovascular accident and promptly referred him to the psychiatry and neurology department for review.

It was at the neurology consultation, that he was sent for magnetic resonant imaging (MRI) of the brain and was placed on haloperidol 5mg daily.

The MRI result came out as subdural haematoma and at last a final diagnosis was made and the neurosurgical team were invited to review and manage him accordingly as mental changes secondary to chronic subdural haematoma was the diagnosis.

The neurosurgical team planned for a borehole drainage of the haematoma after extensive investigation that included E/u/cr, PT/PTTK/INR, RVS, CVR, FBG, ECG, Urinalysis, and all results were reviewed by the team before surgery.

The surgery was done successfully after a signed consent form was filled.

He did well and after serial check-up, he recovered power globally and the combined neurology, cardiology and neurosurgical team eventually discharged him home well and rational. He was no more incontinent of faeces and urine. He was subsequently followed up by the combined team on an outpatient basis.

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### 3. Discussion

The most common cause of subdural haematoma is head injury that can result from road traffic accident, falls or traumatic attacks such as from armed robbery. Others may be shrinking of the brain due to old age or due to usage of blood thinners such as aspirin and warfarin<sup>3</sup>.

Those at risk of subdural haematoma are those who are prone to head injury such as from car crashes, falls or playing some fast energy sapping sports as horse riding, rugby, hockey or speed car racings. Others may be

- Alcohol abuse
- Cerebral malignancy
- Bleeding disorders
- Using blood thinning medicine such as vasoprin
- Advancing age<sup>3</sup>

Subdural haemetoma may be acute or chronic and may present as

- Confusion
- Weakness

- Headache
- Vomiting and nausea
- Convulsions
- Irrational speech
- Fainting attacks <sup>3,4</sup>

This index patient was a case of chronic subdural heamatoma possibly due to hypertension that was not properly managed<sup>5</sup>. The presentation is rare and intracranial and subarachnoid haemorrhages are more common.

Other causes may include the shaken baby syndrome or battered infant syndrome which account for child abuse and trauma <sup>6</sup>.

Treatment is usually by surgical drainage, which was done for our patient with good outcome<sup>7,8</sup>.

But subdural haematoma may manifest as behavioural abnormality that may lead to miss-diagnosis especially in the absence of a recorded head injury <sup>9,10</sup>.

Our patient presented with such complains of having isolated himself, having locked himself up for about one week, developed irrational talking and behaviours, developed faecal and urinary incontinence that made the first contact doctor to label him a psychiatric patient having diagnosed him as severe depression.

Further evaluation and investigations revealed the correct diagnosis and proper treatment was instituted with good result.

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#### 4. Conclusion

Not all mental health issues are psychological related. Some may just be a traumatic event that can be fixed surgically or medically. A high index of suspicion is very important and having the right diagnostic tool is also important.

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#### Compliance with ethical standards

##### *Acknowledgment*

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##### *Disclosure of conflict of interest*

No conflict of interest to be disclosed.

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