

# Double Incontinence: Unusual Presentation of Post Traumatic Bilateral Extradural Haematoma

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## Abstract

A 31-year-old gentleman woke up with confusion and double incontinence with loss of sensation in bilateral lower limbs after a night out. Clinically, the patient was conscious but confused with no focal neurology and no signs of trauma. The CT brain scan revealed evidence of bilateral extradural haematoma and contusion involving left frontal and temporal lobes. No skull fracture was noted. The patient was successfully operated on and made a complete neurological recovery prior to discharge.

**Keywords:** Double Incontinence, Bilateral Extradural Haematoma, Post Traumatic.

## CASE REPORT

We present an unusual case of a 31-year-old male with confusion and double incontinence 24 hours after a night out. Clinically, patient was conscious but confused with no focal neurology except being unsteady on his feet. The patient's observations showed stable vitals and the pupils were equal and reactive to light. He was scored 14/15 on the Glasgow Coma Scale (GCS) (E4V4M6) with no focal neurology.

The CT scan of head revealed a bilateral acute Extra Dural Hematoma (EDH) seen with mass effect on frontal and parietal lobes bilaterally. The right EDH measured 10.2cm X 4.2cm and the left measured 10cm X 3.6 cm, causing displacement of falx, frontal horns of lateral ventricles and generalised sulcal effacement. Bilateral optic nerve thickening of the optic nerve supported a diagnosis of raised intracranial pressure.

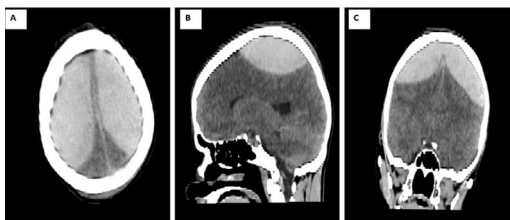


Figure 1: CT Head at Presentation.

1. Bilateral acute extra dural hematoma causing mass effect on frontal and parietal lobes bilaterally on

transverse plane.

2. Compression of parietal lobe on sagittal plane causing effacement of Lateral ventricles.
3. Compression of bilateral parietals lobe on coronal plane.

Patient underwent an emergency bilateral convexity craniotomies and evacuation of EDH. Operative findings were EDH causing significant brain compression with no definite source of active bleeding. EDH was evacuated and a clot near the superior sagittal sinus was left undisturbed to avoid the risk of intra operative sinus bleeding. Dura was hitched to pericranium all around the craniotomy with a view to obliterate the extradural space. Bone flaps were put back and the wound closed with extradural drains. The drains were removed after 24 hours.

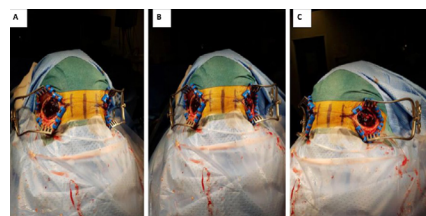


Figure 2: Intra-op Images.

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1. Mini-craniotomy left parietal showed EDH clotted blood.
2. Mini-craniotomy bilateral.
3. Mini-craniotomy right parietal showed EDH clotted blood.

Post operatively the patient was 15/15 on the GCS with no neurological deficit. Day 3 post-op he complained of double vision with some headaches, which later improved. Clinically, the patient had mild bilateral VI nerve palsy.

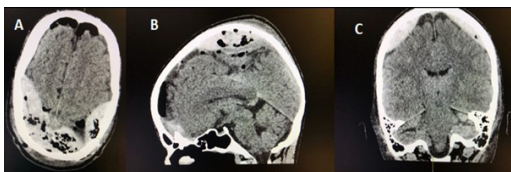


Figure 3: Post-operative CT Head.

Post-op scan revealed moderately sized recurrent extradural clots causing brain compression. He underwent further evacuation of bilateral EDH. Following the second operation he made complete recovery with no neurological deficits. CT head scan prior to discharge was satisfactory with no evidence of recurrence but resolving residual extradural hematoma with no mass effect.

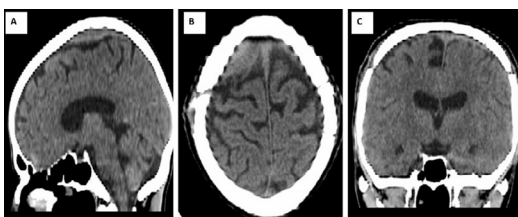


Figure 4: CT Head at the Time of Discharge.

1. Parietal lobe on sagittal plane with minimal residual EDH and lateral ventricle with no effacement.
2. Minimal residual Extra Dural Hematoma causing no mass effect on frontal and parietal lobes bilaterally on transverse plane.
3. No further compression of bilateral parietals lobe on coronal plane.

## DISCUSSION

Bilateral EDH is usually as result of significant head injury and most of the times there is a concomitant injury to superior sagittal sinus with overlying bone involvement. Such cases are reported in the literature managed often by surgery. These cases present most commonly with deteriorating neurological status due to raised intracranial pressure. Our patient presented with confusion and double incontinence with weakness in lower limbs 48 hours after a blunt trauma to head. Patient did not report headache. This is a very unique presentation of bilateral EDH. Prompt surgical intervention lead to a successful outcome. The patient underwent bilateral mini-craniotomy and evacuation of bilateral clots which is the standard approach. We decided on a mini-craniotomy against a large trauma flap on the basis that our patient

was conscious with no clinical symptoms of raised ICP at presentation. The patient made a complete neurological recovery and regained functional independence at the time of discharge.

## ABBREVIATIONS

CT: Computed Tomography, GCS: Glasgow Coma Scale, EDH: Extra Dural Hematoma, Post-Op: Post-Operative, ICP: Intra Cranial Pressure.

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