

# MANAGEMENT AND OUTCOME OF SPONTANEOUS CERVICAL EPIDURAL HEMATOMA: CASE REPORT AND REVIEW OF THE LITERATURE

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## Background

Spontaneous spinal epidural hematomas are rare and potentially disabling neurological emergencies. It leads to devastating neurologic outcomes, and most patients do not recover completely. The clinical presentation is diverse and includes a severe acute attack, radiating pain at the back, interscapular, or neurological deficits. We report a case of a young woman, 24-year-old, that was admitted to our department for sudden non-traumatic cervical spinal cord compression syndrome (Type A of the American Spinal Cord Injury Association "ASIA A") including intense cervical back pain, sensory loss, and tetraplegia. Her past medical history was unremarkable. The MRI confirmed a cervical mass responsible for the spinal cord compression, and the emergent surgical intervention allowed us to evacuate acute C3-C7 hematoma. Unfortunately, the patient never recovers from the neurologic deficit despite the emergent management of her case followed by functional musculoskeletal rehabilitation for two years.

KEYWORDS Spinal Cord Compression, Hematoma, Epidural, Spinal, Cervical Vertebrae, case report

## Introduction

Spontaneous spinal epidural hematomas are the idiopathic accumulation of blood within the spinal canal's epidural space,

causing symptoms varying from general back pain to complete paraplegia [1]. It is a very rare cause of acute spinal cord compression and is estimated to occur every year in approximately

0.1% of 100,000 individuals [2]. MRI is the radiological investigation of choice. Fifty percent of spontaneous spinal epidural

hematoma patients do not fully recover, and 30% of patients presented with ASIA A classification did not improve with surgery [3]. We present a case of a 24-year-old woman who never recovers from her ASIA A spontaneous cervical epidural hematoma despite rapid surgical evacuation in an emergency setting, 48

hours of the tetraplegia onset.

Case report A 24-year-old woman was admitted to our department for sudden intense cervical back pain and tetraplegia within 48 hours. The patient denies neck trauma, and her past medical history was unremarkable. The physical examination revealed superficial and deep sensory palsy with the sensibility level at C4. The osteotendinous reflexes were abolished in all 4 limbs and acute urinary retention. There was no fever, and the patient was in general good health status. This cervical spinal cord compression is classified as ASIA A (Table 1). The cervical MRI performed in emergency showed a posterolateral right epidural masse that is heterogeneous in T1-weighted, hypointense in T2-weighted, and compressing the dural sheath from the 3rd to the 7th cervical vertebrae (Fig. 1). These findings were suggestive of an epidural tumour lesion. The patient underwent surgical decompression the same day. Patient under general anaesthesia and in a supine position, we did laminectomy at C4-C5-C6 and got directly on a bunch of clotted blood in direct contact with dura sheath. This large extradural hematoma was completely evacuated. A subsequent search for a hemorrhagic defect proved to be unsuccessful. A detailed rehabilitation schedule was established for the early rehabilitation program, which included a passive joint range of motion training of lower limbs, active joint range of motion training of upper limbs, muscle strength enhances training, pulmonary function training, and position change training. In spite of intense postoperative rehabilitation, the patient remained at grade ASIA A classification with severe sequelae after 2 years.

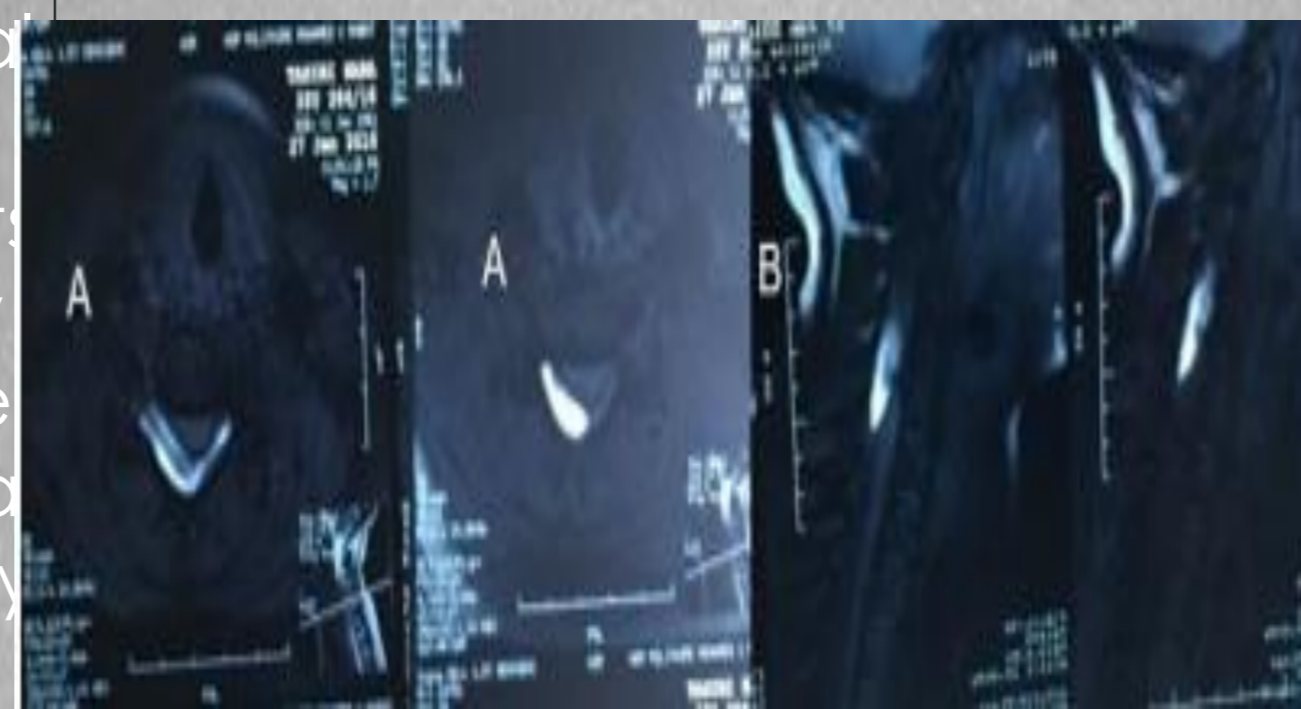


Figure 1: T1-weighted MRI of the cervical spine showing hyperintense epidural fluid collection, identified posterior to the cord and eccentric toward the right on A/axial view and B/sagittal view, at the C4-C7 levels measuring up to 2 cm thick. The cord appears compressed most pronounced at the C5 and C6 levels.

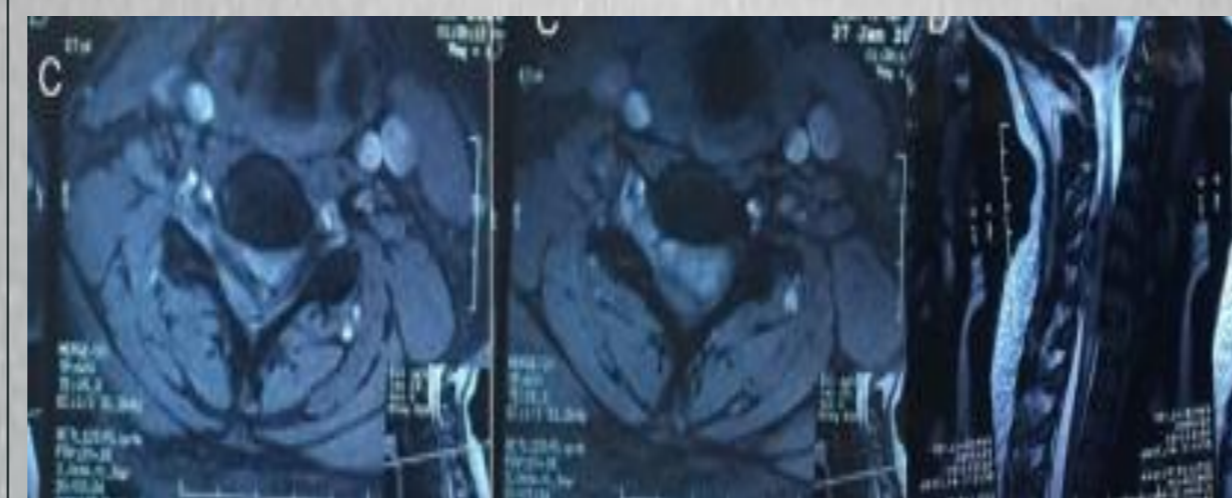


Figure 2: T2-weighted MRI of the cervical spine showing hypointense lesion on C/axial and D/sagittal view of same characteristics as previous.

## Discussion

Discussion Taking the patient directly from ICU to the OR for emergency cervical decompression by laminectomy of C4-C5-C6 for spontaneous cervical hematoma revealed by sudden tetraplegia is the best medical decision to manage this kind of patient. We hope that the patient will recover from the nervous assault after surgery. Nevertheless, that was just a hope that may or may not be all the patient's reality even though it happened to be the same case. MRI is the gold standard radiological investigation for patients presenting with signs and symptoms of spinal cord injury. In most findings, the spontaneous cervical hematoma was of high intensity or heterogeneous in T1-weighted and low intensity in T2-weighted [4–6]. Different theories have supported that the internal epidural plexus is responsible for bleeding into the epidural space. This may explain the heterogeneity of the lesion on T1-weighted for the mixture of old blood clots and the persistent venous bleeding. Patients who present with more severe symptoms within a shorter time frame tend to have larger hematomas; these are associated with worse outcomes, particularly when four or more spinal segments are involved [7–9]. Moreover, these were the same findings of our reported case. On the other hand, a literature review by Figueroa et DeVine (10) has shown that some individuals presenting with an ASIA A deficit have demonstrated recovery. So, the decision of surgery for spontaneous spinal hematoma must not depend on the heaviness of the neurological deficit nor on time wasted by the patient before seeking medical care; for the simple reason that some of these patients do recover after surgery. Many authors reported surgical management by decompressive laminectomy and hematoma evacuation [4,5,11,12]. However, the results were quite diverse and different from one patient to another, even if they had the same clinical presentation. Nevertheless, Hongo et al. [13] performed hematoma removal and decompression by corpectomy from the front of C3–C5 at approximately 32 h after the onset of symptoms. The patient could stand and walk 3 days after the operation without fixation. It may be possible that the extent of recovery does not depend only on the heaviness of the nervous palsy prior to surgery but also on the surgical technique used for the decompression of the dural sheath, nerves, and nerve roots. Patients with minimal symptoms prior to therapy are more likely to acquire complete recovery than those with major deficits in sensorimotor functioning. A hallmark prognostic indicator of pretherapy neural deficits is the ASIA score. Baeesa et al. [14] reported significant recovery with conservative therapy for selected patients with a mild to moderate neurological deficit who demonstrated early neurological improvement. Kim et al. [15] concluded that conservative therapy could be feasible for selected patients with an ASIA score of C, D, or E demonstrating spontaneous early neurological recovery. At the same time, the ASIA A or B patients should undergo emergent decompressive surgery. However, decompressive laminectomy should remain readily available, given the inverse correlation between the operative interval and better recovery.

## CONCLUSION

Urgent surgical decompression is the treatment of choice for spontaneous cervical epidural hematoma with a neurological deficit. However, which patient not to operate in the emergency setting.

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