Case Report

Traumatic Extradural Hematoma Presenting as Monoplegia in an Elderly Female

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ContraLateral weakness following cranial injury has been emphasized as a clinical manifestation of extradural hematoma (EDH) since long. Only few reported cases where patients with traumatic extradural hematoma presented with monoplegia. A 53 year female presented with history of a fall in the bathroom in the morning of one day duration. Following the fall she had transient loss of consciousness and recovered. After 8-10 hours of the incident she had two episodes of vomiting and was complaining of mild headache. She was taken to a local hospital where the attending physician noted the weakness of right lower limb. An urgent CT scan brain was performed and it showed a large extradural hematoma over left high parietal region with mass effect and adjacent cerebral edema (Fig. 1).

At the time of examination in emergency room at our hospital the patient was conscious, obeying commands and opening her eyes spontaneously. Her cranial nerves were normal. Pupils were bilateral equal and reacting to light. She had grade 1/5 power in right lower limb. Power in other limbs was normal. Deep tendon reflexes were exaggerated in right lower limb. Plantar were flexor. In view of focal weakness the patient underwent left parietal craniotomy and evacuation of a thick extradural blood clot. Over a period of 72 hours after surgery the patient recovered completely in the power of the right lower limb.

The clinical signs and symptoms of EDH range from asymptomatic to frank coma. Common signs or symptoms of traumatic extradural hematoma include lucid interval, pupillary abnormalities, hemiparesis, decerebration, seizures and Cushing reflex (heart rate, respiration and blood pressure changes). In a series reported by Hossain et al the common clinical symptoms were altered sensorium (61%), headache / Vomiting (56%), lucid interval (28%), neurodeficit (hemiparesis) (19%) and seizure (13%) respectively. Monoparesis is an extremely uncommon presentation of traumatic extradural hematoma and to best of our knowledge there are only two such cases are reported. Anatomically it is known that vertex motor cortex subserves the hips, knees, and feet and a mass lesion (i.e. hematoma) here can cause mechanical compression producing motor weakness (paraplegia and/or rarely monoplegia). In the present case monoplegia can be...
explained by the fact that the hematoma was overlying the motor cortex only on one side (in contrast to previously reported cases of vertex hematomas where patients presented with paraplegia). As seen in the present case, once a diagnosis is confirmed on imaging, surgical evacuation is recommended as it will relieve the pressure related effect and will result in rapid recovery of the monoplegia.  

REFERENCES