Traumatic subdural hygroma

From the Greek hygros, meaning wet. AKA traumatic subdural effusion, AKA hydroma. Excess fluid in the subdural space (may be clear, blood tinged, or xanthochromic and under variable pressure).

Traumatic subdural hygroma (TSH) is an accumulation of cerebrospinal fluid (CSF) in the subdural space after head injury.

**Epidemiology**

It appears to be relatively common, but its onset time and natural history are not well defined.

**Etiology**

It is almost always associated with head trauma, especially alcohol-related falls or assaults

Skull fractures were found in 39% of cases. Distinct from a chronic subdural hematoma, which is usually associated with an underlying cerebral contusion, and usually contains darker clots or brownish fluid ("motor oil" fluid), and may show membrane formation adjacent to the inner surface of the dura (hygromas lack membranes).

Secondary to tear in the arachnoid mater

post surgical, e.g. haematoma evacuation, ventricular drainage

see [Traumatic subdural hygroma after endoscopy](https://operativeneurosurgery.com/).

see [Postoperative contralateral subdural effusion](https://operativeneurosurgery.com/).

It has been described as a complication of cerebellopontine angle tumor requiring surgical evacuation

see [Subdural hygroma after cerebellopontine angle tumor surgery](https://operativeneurosurgery.com/).

**Classification**

“Simple hygroma” refers to a hygroma without significant accompanying conditions. “Complex hygroma” refers to hygromas with associated significant subdural hematoma, epidural hematoma, or intracerebral hemorrhage.

Based on clinical features and dynamic observation of CT scanning, TSHs were classified into four types: resolution, steadiness, development and evolution. The resolution type often occurred in the prime of life, and the patients had normal intracranial pressure and good prognoses after conservative treatment. The elderly made up the majority of the steadiness type. Their main clinical manifestations included headaches, dizziness, nausea, vomiting, abnormal mentality, etc. Generally, no positive nervous systemic sign related to TSH was observed. The prognoses of the steadiness type treated by conservative therapy were also satisfactory. The development type was common in babies and children and mainly manifested as progressively increasing intracranial pressure, mild hemiplegia, aphasia and abnormal mentality. The patients with development type often needed
surgical treatment where there was an associated risk of dying from accompanying cerebral parenchymal damage or postoperative complications once in a while. The evolution type with chronic subdural haematoma occurred between 22 and 100 days after TSH and in the cases of small hydromas treated conservatively, with mild accompanying cerebral damage, characterised by the polarised age, and chronic increased intracranial pressure, there was always a good prognosis after surgery 3).

**Pathogenesis**

Considered a benign epiphenomenon of trauma, the pathogenesis of TSH is still unclear and many questions remain unanswered.

Tsuang et al., have found that many patients with mass effect have concomitant hydrocephalus. Patient experiencing this occurrence were studied, and the pathogenesis of this phenomenon was discussed in the context of recent advances in the understanding of CSF circulation 4).

A trivial trauma can cause a separation of the dura-arachnoid interface, which is the basic requirement for the development.

If the brain shrinks due to brain atrophy, excessive dehydration or decreased intracranial pressure, fluid collection may develop by a passive effusion. Most resolve when the brain is well expanded. However, a few become chronic subdural haematomas, when the necessary conditions persist over several weeks. Since the majority of patients do not show a mass effect, surgery is rarely required. Outcome is closely related to the primary head injury

The complexity depends on various factors including the dynamics of absorption and expansion, duration of observation, and indication and rate of surgery, besides variety of the primary head injury in types and severity 5).

Small subdural effusion detected in the first 24 hours posttrauma evolved into TSH suggesting that this is an early lesion 6).

**Pathology**

They generally occur along the supratentorial cerebral convexities; occurrence in the posterior fossa is generally rare 7).

**Diagnosis**
Crescentic CSF density/signal accumulation of CSF in subdural space that does not extend into the sulci. Vessels may cross through the lesion in contrast enhanced studies.

It is not uncommon for chronic subdural hematomas (SDHs) on CT reports for scans of the head to be misinterpreted as subdural hygromas, and vice versa. Magnetic resonance imaging (MRI) should be done to differentiate a chronic SDH from a subdural hygroma, when clinically warranted. Elderly patients with marked cerebral atrophy, and secondary widened subarachnoid CSF spaces, can also cause confusion on CT. To distinguish chronic subdural hygromas from simple brain atrophy and CSF space expansion, a gadolinium-enhanced MRI can be performed. Visualization of cortical veins traversing the collection favors a widened subarachnoid space as seen in brain atrophy, whereas subdural hygromas will displace the cortex and cortical veins.

**Differential diagnosis**

Imaging differential considerations include

chronic subdural haematoma: MRI may required to differentiate as they can have an identical appearance on CT

atrophy/involutional change with enlargement of the subarachnoid space.

**Outcome**

About half of the asymptomatic ultimately evolve into chronic subdural hematomas (CSDHs), most of
which will be inevitably treated by surgical evacuation. With the emergence of subdural hydroma (SDH), rupture of bridge-veins, bleeding of the hydroma wall, hyperfunction of fibrinolysis and increasing protein content in the hydroma are some of the traditionally cited explanations of the pathogenesis evolving into CSHD.

Compared with peripheral venous blood, inflammatory cytokines were elevated in TSH and CSDH demonstrated by a number of investigators. Neoformation of capillaries, vascular hyper-permeability, serum protein exudation and other characteristics of aseptic inflammatory reaction were observed. Meanwhile, steroid was applied to treat CSDH in several groups, which was generally used as an effective anti-inflammatory agent. Based on systemic thinking, we hypothesize that TSH and CSDH are different stages, with different appearances, of the same inflammatory reaction. The evolution from TSH into CSDH and propagation of CSDH seem to be the results of local aseptic inflammation.

It is one possible origin of chronic subdural hematoma (CSDH). The clinical characteristics of TSH evolving into CSDH include polarization of patient age and chronic small effusion. The injuries usually occur during deceleration and are accompanied by mild cerebral damage.
