In *Two Hemispheres* neurologists relate their unique experiences from the perspective of being both physician and patient. For submissions, contact T Kushner at kushnertk@gmail.com

Subdural Hematoma

From Inside and Out

GRANT GILLETT

It was nearing midnight, but we were doing well and had been very sensible. It was a 360 km drive, but we had left at 6:30 with a view to arriving about 11:30 after a refreshment stop half way. I was driving and felt good and there was only 35 km to go when I said to my wife, "I feel great; you can relax if you're tired." I distinctly remember entering North Dunedin and noting the 50 km/h limit that she so often reminds me of, but then what happened next is a bit of a blank until the massive *bang* of the crash itself. My immediate thought was, *We are only five minutes from home*. And evidently that was what I said while I was wandering about unharmed except for a bleeding wound on the back of my head. My wife, fortunately, only sustained whiplash. I do not remember being transferred to the hospital (100 yards away) nor do I remember clearly what ensued although, according to accounts, I seemed cognitively intact.

The scan showed that I had a massive right-sided subdural hematoma inside the skull pressing on the brain, and I remember thinking *Just what one would expect if the patient was on anticoagulants*. There was, however, a slight puzzle as to why I was so neurologically intact given that subdural hematomata normally arise from a contused and bleeding brain. I had had a patient some years ago who was about my age and on anticoagulants. He was admitted with headaches, but otherwise was neurologically intact despite his scan showing a huge relatively acute looking subdural hematoma, like mine. In his case, because of its size, I opted to remove it, and had to perform a limited craniotomy to do so. I found a small, tortuous atherosclerotic artery on the surface of the brain (which otherwise looked intact) bleeding into the subdural space. I cauterized it and stopped the bleeding, closed his head up, and he emerged unscathed apart from the scalp wound and a piece of bone needing to heal itself.

In my present situation, I was well known to the neurosurgeon looking after me, as I often attended both the neuroradiology meetings and the weekly clinical neuroscience presentations, at which I occasionally presented. I told him of this case and the fact that I had reflected that I had not really needed to perform the operation. The puzzling mismatch between radiology and the clinical picture prompted a thoughtful review of my own case, in which a somewhat unreal

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set of events then unfolded while my in-ward physiotherapy and daily clinical reviews continued.

It became clear that the massive subdural hematoma was having a minimal space-occupying effect (0.6 cm of midline shift) and, therefore, did not warrant surgical removal given my robust conscious and cognitive state. That was a relief because, however lightly one speaks of burr-holes to one's patients, the actual prospect of having a hole drilled in one's own head substantially exercises the sense of one's own well-being and mildly unsettles ones' *eudaimonea* (inner harmony). I am grateful that my surgeon, perhaps in deference to my own professional opinion, insisted on free and frank discussions of the way forward as suggested by the best Hippocratic advice,[1] and the editorial recommendation of the *British Medical Journal*.[2] He inclined toward conservative management, and I applauded on the sidelines (if one can do so from the center of the ring under the lights, as it were). In any event, I was not in any rush to have what Wooster might refer to as the "first person bonce" violently penetrated with non-blunt instruments in the form of a brace and bit unless there was no reasonable alternative.

The pressing problem (forgive the pun) created by the hematoma was a nagging, unrelenting, headache of a type that gave me instantly heightened empathy and sympathy for my patients with intracranial pressure. It was there hour after hour through all my waking day and following the normal instructions—lying down for a rest—had absolutely no effect. Then came bedtime at the end of tiring days just getting by with every minor physical task a challenge, and no rest to look forward to; in fact, I experienced sleepless nights with a headache untouched by normal pain relief and, cruelly relative to anticipations, worsened by lying down. The whole experience was a low-intensity unsettling nightmare.

The incoordination or apraxia was to be expected from a subdural hematoma affecting the right parietal lobe, but it was utterly frustrating and exasperating despite its ready explanation. One cannot talk oneself through the disturbing experience occasioned by anything from putting a shirt on to doing up shoelaces to freeing oneself from entangled bed covers.

Undoubtably the most unsettling experience was a Jacksonian seizure with all the usual hallmarks. It began while I was undergoing a gentle physiotherapy assessment or exercise involving a walk along the ward corridor on the third or fourth day of my admission. The feeling that one's hand is shaking itself like a frenzied beast in desperate need of a calming word is only made more alarming by the fact that words, no matter how calming or soothingly intoned, make not the slightest difference. To say it disturbs one's equanimity is to understate the case. Thankfully it was an isolated event, however classically Jacksonian it was, and however much, ironically, I am one of the great man's greatest fans (some tributes are too costly to pay). One or two further insider observations are worth making: for an academic whose life is prominently spent generating text such as the current report, to have a left hand that one cannot trust to hit the correct keys on a keyboard is highly disconcerting and the last straw that definitively impairs the proverbial camel. Combine that with a pervasive executive apraxia and neurogenic fatigue and one has a fraught return to work.

The next hurdle was the neuropsychological assessment. To tell oneself as firmly as one can that this is not a competition between oneself and the reference group is a credo that certain personality types find hard to live by

in the actual moment of trial. A kind of determination to reassure oneself of one's own worth and a desperation not to be seen as an invalid, cripple, or other worthy object of charity according to all the time-honored (but disgraceful) stereotypes leads to a level of motivation and performance anxiety that makes the event quite stressful and exhausting.

Perhaps the last curious experience was the automated perimetry (a question had arisen about my visual fields because I kept bumping into things on my left). I rapidly realized that the phenomenon of blindsight[3] meant that I could perform as a human being (only press the buzzer when you see something) or as a monkey (press whenever you get the impresssion of a stimulus). Doing the latter resulted in a very high detection rate and exemplary visual fields.

All in all, the view from the inside out confirmed what bioethicists have been saying (after the Hippocratics) for years: involve the patient, anticipate the patient's fears and anxieties, act with compassion and inclusively, and treat the clinical experience as a joint problem-solving exercise, and the professional–patient relationship will make the best possible contribution to the clinical regimen.

Notes

1. Lloyd G. *Hippocratic Writings*. London: Penguin; 1978, at 71, 142.
2. Coulter A. Paternalism or partnership? *British Medical Journal* 1999;319:719–20, at 717.
3. Weiscrantz L. *Consciousness Lost and Found* Oxford: University Press; 1997.