

Response to Comment on “Massive spontaneous parasellar and retroclival subdural hematoma”

Zongli Han¹ · Yanli Du² · Hui Qi¹ 

Received: 4 February 2017 / Accepted: 7 February 2017 / Published online: 14 March 2017
© Springer-Verlag Berlin Heidelberg 2017

Dear Editor,

We thank Dr. Bert Boshe et al. for their interest in our paper.

Most spontaneous extra-axial hematomas are located supratentorially, usually in the region of the sylvian fissure or supramarginal gyrus [1]. Some spontaneous extra-axial hematomas in the absence of trauma, aneurysm, arteriovenous malformation, tumor, or coagulopathy have been reported sporadically [2–4].

We agree with the author that recurrence of some hematoma is associated with deficiency of coagulation factors. Clinically, we occasionally encounter some traumatic and spontaneous hematomas recurring repeatedly after surgery, which were resolved with frozen plasma infusion. Dr. Bert Boshe has given us a new idea for this kind of hematoma, and we now also try to contact the patient to ask whether the local hospital can exam the F XIII activity, because the patient is in another city far away from us.

However, our case more likely suffered from the pituitary apoplexy or arterial origin bleeding even though no angiography origin was confirmed [3], in which the hematoma centered around the sella turcica.

In our case, the course and neuroradiological imaging are all acute phase, which is different from the cases that Dr. Bert Boshe et al. reported. Second, the case in our paper, and the cases our paper cited are for the courses which are self-limited and should not be resolved without plasma infusion and operation if the

etiology is deficiency of FXIII. As we all know, both acute and chronic subdural hematoma with obvious neurological or mid-line shift need trepanation and drainage or hematoma evacuation with craniotomy because the hematoma can not be self-limited, especially with FXIII deficiency, and this type of hematoma becomes severe because of the excessive activation of both the clotting and fibrinolytic systems [5]. We have followed up the patient for about two years, and no recurrence was observed.

Compliance with ethical standards

Funding No funding was received for this study.

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval All procedures performed in the studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

Informed consent This article does not contain any studies with human participants performed by any of the authors.

References

1. McDermott M, Fleming JF, Vanderlinden RG et al (1984) Spontaneous arterial subdural hematoma. *Neurosurgery* 14(1):13–18
2. Avis SP (1993) Nontraumatic acute subdural hematoma. A case report and review of the literature. *Am J Forensic Med Pathol* 14(2):130–134
3. Chhiber SS, Singh JP (2010) Acute spontaneous subdural hematoma of arterial origin: a report of four cases and review of literature. *Neurol India* 58(4):654–658
4. Sung SK, Kim SH, Son DW et al (2012) Acute spontaneous subdural hematoma of arterial origin. *J Korean Neurosurg Soc* 51(2):91–93
5. Kawakami Y, Chikama M, Tamiya T et al (1989) Coagulation and fibrinolysis in chronic subdural hematoma. *Neurosurgery* 25(1):25–29

✉ Hui Qi
publicjournal@163.com

¹ Department of Neurosurgery, Peking University Shenzhen Hospital, 1120 Lianhua Road, Futian District, Shenzhen 518036, Guangdong, People's Republic of China

² School of Medical Technology and Nursing, Shenzhen Polytechnic, Shenzhen, Guangdong, People's Republic of China