Chronic subdural hematoma is a frequently encountered entity in neurosurgery in particular in elderly patients. It commonly arises after 60 years. Several other factors that contribute. In most cases, no etiology is found (1-3). Contributing factors like chronic alcoholism and anticoagulant treatment are determined. The initial bleeding may be spontaneous or cause by minimal trauma. At first, hemorrhage often goes unnoticed. It progressively takes volume and compresses brain. Signs and symptoms can vary widely among individuals. CSDH is rightly called the great imitator (4). It is able to imitate every conceivable symptom from simple headache to coma. The symptoms are generally very insidious and develops gradually. Headache is a very frequent symptom in CSDH. Deterioration of patient’s physical condition Gait disturbance, Weakness + hemiparesis, Memory disturbances, Dizziness, Psychic disturbance, Consciousness disturbance may occur (5). Less frequently epilepsies, hemiplegia can arise.

There is a high variance in surgical treatment of CSDH in medical literature. Conservative treatment consists of hydration in this population who are usually dehydrated because of their advanced age and alcohol consumption. Recently, a treatment using Dexamethasone is proposed with good results (6). We used this treatment in our department in very old patients and in patients with generally poor state. I find that the outcome of such procedures is mixed. For example, this treatment is not appropriate for patients who have multiple layers of subdural hematoma with different dates (7). It should not be used for patients with neurological deficits and signs. In these patients a surgery shall be provided to evacuate hematoma.

At any rate, the surgery is the gold standard of CSDH treatment. Varied and wide surgical techniques have been reported in medical literature: craniotomy and direct evacuation of hematoma. Trephine hole. One or two trepanation holes. Implantation of drain or not (8,9).

In these patients older than average population, I proposed a minimally invasive surgery reported in a paper in 2011 (10). We measure the hematoma volume in advance on preoperative CT scan imaging by software funding for this purpose. The procedure is performed under local anesthesia with a mild disturbance may occur (5). Less frequently epilepsies, hemiplegia can arise.

After a halfhour to one hour observation period in recovery room, the patient returned to his room and post-operative observation resumed with an evaluation of the Glasgow Coma score, neurological examination and measurement of constants of blood pressure immediately after surgery and then every hour up to 4 h and then spacing the review to once a day. Patients are allowed to get up and mobilized two hours after surgery. The patients received a control CT scan the day following the surgery. Discharge from hospital is two or three days post-operation. I reassess patients a month after surgery with a control CT scan. I do not introduce any treatment other than analgesics. Patients are advised to drink water. More than patients are operated by this procedure.

More than 250 patients have been operated by this technique. The preliminary results have been published in 2011 (10). The data of all patients will be analyzed and published shortly.

REFERENCES