A 77-year-old female patient was admitted to our clinic with head injury from falling downstairs. It was learned from the anamnesis taken from the relatives that she had heart surgery 3 months ago and was using clopidogrel and metoprolol. On admission, blood pressure was 176/85 mmHg, and pulse rate was 75 /minute. On physical examination, her Glasgow Coma Score was 9 (eye 3, motor 3, verbal 3). There was subcutaneous emphysema, especially on the left side of the scalp. The patient had anisocoria, the left pupil diameter was larger than the right. Hematological, biochemical and coagulation parameters of the patient were within normal limits.

Computed tomography showed an acute subdural hematoma surrounding the cerebral convexity on the left, measuring 19 mm in its thickest part (red asterixis). Parafalcine subdural hematoma, measuring 19 mm in its thickest part (black asterixis).

Parafalcine subdural hemorrhage was first described by Arring and Evans in 1940 as an atypical localization (1). On the other hand, it has become more recognized due to the widespread availability of computed tomography since that day (2). Hemorrhages in the parafalcine region constitute 9-15% of all blunt trauma-induced intracranial hemorrhages (3). Although small amounts of parafalcine hemorrhages are benign, mortality is high in hemorrhages with high volume bleeding and high convexity (2,3).
Conflict of interest: Authors declare no conflict of interest.
Ethic: Informed consent was obtained from the patient.
Approval of final manuscript: All authors

REFERENCES