Disseminated Intravascular Coagulation, Hypodense Spontaneous Acute Subdural Haematoma in a Case of Psoriasis

Dear Editor

Psoriasis is a chronic, immune-mediated inflammatory disease affecting 2%-3% of the world’s population characterized by the presence of red, thick, scaly lesions.1 A 40-year-old gentleman on irregular treatment for psoriasis for the last seven years developed a headache and a mild fever four days back that was relieved after treatment. One day back, after an episode of vomiting and giddiness, he fainted, fell down and lapsed into altered sensorium. At admission, his vital parameters were normal. On examination, he had extensive lesions of psoriasis (figure 1). There was evidence of oral bleeding but no haematuria. CT scan showed a large hypodense collection over right fronto-temporo-parietal region suggestive of acute subdural haematoma (SDH) with a mass effect and midline shift (figure 2). He had bilateral papilloedema and retinal hemorrhages. Right pupil was dilated, fixed and non-reactive to light with left sided hemiplegia. Haemoglobin was 4.2 gm%, total leucocyte count was 11,000/mm³ and haematocrit was 10. Serum bilirubin was 3.2 (Total), urea was 38 mg%. Platelet count was 38,000, APTT -> 5 minutes (control 58 seconds), prothrombin time was 120 seconds (control-16 seconds), and INR was 7.5. A diagnosis of severe anaemia, disseminated intravascular coagulation with acute subdural haematoma in a case of psoriasis was made. Being an autoimmune disorder, psoriasis can be associated with many acquired bleeding disorders.2,3 Although both disseminated intravascular coagulation (DIC) and psoriasis do occur relatively frequently; however, these entities have been described rarely in the literature.4 DIC is a complex complication of many systemic inflammatory disorders which either lead to the release of procoagulant material into the circulation or cause widespread endothelial damage or platelet aggregation characterized by widespread intravascular deposition of fibrin with consumption of coagulation factors and platelets.4 Any form of systemic inflammation can virtually cause activation of coagulation, ranging from changes in molecular markers in coagulation factors with equivocal clinical significance to its most full-blown variant (DIC).5 In the present case, it is difficult to postulate what triggered the cascade leading to DIC; however, it resulted in a devastating complication i.e. massive acute SDH. To further complicate the issue, the haematoma was hypodense on CT scan, probably because of

Figure 1: Diffuse lesions of psoriasis

Figure 2: CT scan showing right fronto-temporo-parietal hypodense acute subdural haematoma with mass effect and midline shift
severe anemia and low haematocrit. Managing a patient with a wide spectrum of problems is a challenge and follows the basic principles including the treatment of the underlying disorder. Other modalities include use of immunosuppressive drugs (cyclophosphamide, corticosteroids), plasmapheresis, and immunoglobulin. (Iran J Dermatol 2008;11: 135-136)

Amit Agrawal, MD1; Adarsh Lata Singh, MD2
1. Department of Surgery
2. Department of Dermatology, Datta Meghe Institute of Medical Sciences, Sawangi (Meghe), Wardha (India)

Corresponding Author:
Amit Agrawal, MD
Datta Meghe Institute of Medical Sciences
Sawangi (Meghe), Wardha- 442004,
Maharashtra, India.
Email: dramitagrawal@gmail.com

References