

we performed CT perimyelography which showed subtle CSF leakage at the levels of avulsions.

Treatment of intracranial hypotension ranges from conservative management, such as bed rest, overhydration, mild hypertension, and caffeine, to invasive procedures. Most patients are successfully treated conservatively. Among invasive procedures, a blood patch is one of the most common interventions [3]. Urgent management may include positioning the patient in the Trendelenburg position [4]. In our case, the CSF leakage ceased after positioning.

In conclusion, our case demonstrates the importance of being aware of the trauma and IH association, even in the absence of head or spinal trauma. Moreover, several lessons should be learned from this case. First, diagnosing intracranial hypotension is challenging due to the absence of pathognomonic signs on standard CT scans; therefore, additional tests such as perimyelography need to be employed.

Second, a negative or very low intracranial pressure should always lead to considering the presence of intracranial hypotension due to cerebrospinal fluid leakage as a possible cause of coma. And third, it is crucial to move the patient with known or suspected CSF leakage from the standard semirecumbent position to the supine position or, in urgent situations, to the Trendelenburg position.

Conclusion

Intracranial hypotension is a relatively rare, but clinically significant finding that may affect the final clinical outcome. We should always consider its presence in patients where there is no other, clinically more relevant explanation for the deterioration of consciousness.

Written consent for publication was obtained from the patient

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